SAR Team
Health Records Department
Glasgow Royal Infirmary
8 – 16 Alexandra Parade
Glasgow
G31 2ER

NHS
Greater Glasgow and Clyde

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

Date: 18 May 2026
Your Ref: 100319
Ref: SAR / ACCESS /CD
Enquiries to: Catrina
Direct Line: 0141 201 3381
Email: catrina.doogan@nhs.scot

Dear Sir / Madam

Re: Subject Access Request under the General Data Protection Regulation

Patient: NEIL CASSIDY DOB: 25/04/1982

Thank you for your recent request in which you seek a copy of your client's personal information.

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

GLASGOW ROYAL INFIRMARY RECORDS
STOBHILL HOSPITAL RECORDS

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

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

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

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

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

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

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

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

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

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

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

Data Protection Officer
Information Governance Department
NHS GG&C – 2nd Floor
1 Smithhills Street
Paisley
PA1 1EB
Email:

Yours sincerely

SAR Team

ELECTRONIC PATIENT RECORDS

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

Including:

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

Clinic Letter

NHS
Greater Glasgow and Clyde

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

Dr. L Zhang
Townhead Medical Practice
Townhead Health Centre
16 Alexandra Parade
Glasgow
G31 2ES

Main Switchboard: 0141 201 3000
Department: Acute Stroke Team
Contact Tel: 0141 451 5197
Enquiries to: morag.greenlaw@nhs.scot
Letter Date: 24/06/2025
Reference: HS/mg
Dictated Date: 24/06/2025
Transcribed Date: 26/06/2025

Dear Dr. L Zhang,

Neil Cassidy; D.O.B: 25 Apr 1982; CHI: 2504826311
2/2, 14 INGLEBY DRIVE, Glasgow, Lanarkshire, G31 2PT

Attendance: Specialty - Geriatric Medicine; Clinic - STHSGE401D-DR H SLAVIN STROKE TUESDAY PM CLINIC
Date and Time of Appointment - 24/06/2025 15:15

Clinical Comments:
Mr Cassidy did not attend his follow-up appointment at my Cerebrovascular Clinic on 24 June 2025.

I note that since his discharge from the ward he attended for a period of ambulatory ECG monitoring which although incomplete, showed no evidence of atrial fibrillation.

He has completed his neurovascular investigations and has been prescribed appropriate vascular secondary prevention. I have therefore not offered him a further clinic appointment at present. Please do not hesitate to re-refer if you have any concerns in the future.

Kind regards

Yours sincerely

Dr Helen Slavin

Consultant Physician in Stroke Medicine

Electronically Signed: Dr Helen Slavin, Consultant

cc.

Pathfinder SL — Cassidy, Neil

Stobhill Hospital — Confirmed — 3 Lead Holter Report

Patient ID: 2504826311 | Date of Birth: Sun 25 Apr 1982 (42 years) | Gender: Male

National ID:
Hospital / Practice: Stobhill Hospital
Referring Doctor: Dr Helen Slavin
Case:
Order:
Ward:
Recorded: Mon 17/03/2025 15:31:00
Analyzed Length: 1 day 7 hr 35 sec, 7.7% artifact
Analyzed by: Lisa Kane Tue 22 Apr 2025

Indications (reason for test) :

stroke ?paf

Beats

Beats	Total	Normal		Ventricular		Supraventricular		Paced	
Count	154,239	153,162	99%	919	<1%	14	<1%	106	<1%
Max/Hour		7,183	Tue 18, 18:00	131	Tue 18, 14:00	4	Tue 18, 08:00	45	Tue 18, 19:00

Intervals:							
RR Interval	Longest	1.33 s	(Tue 18, 07:32:31)	Shortest	311 ms	(Tue 18, 19:45:01)
NN Interval	Longest	1.11 s	(Tue 18, 07:35:36)	Shortest	403 ms	(Tue 18, 17:52:08)

Heart Rates

Heart Rates (1 min avg)	Rate (bpm)	Time
Max	138	Tue 18, 18:30
Min	61	Tue 18, 07:30
Mean	90	
Mean HR (Day)	96	07:00:00 - 23:00:00
Mean HR (Night)	73	23:00:00 - 07:00:00

Rate Dependent Events

Rate Dependent Events	Count	Most Severe Rate (bpm)	Longest (beats / secs)
Pause	0	-	-
Dropped Beat	-	-	-
Bradycardia	0	-	-
Tachycardia	766	148 : Tue 18, 20:27	1247 beats : Tue 18, 20:27

Ventricular Arrhythmias

Ventricular Beats : 919 (<1%) Max/Hour : 131 (Tue 18, 14:00) Max/Minute: 7 (Tue 18, 14:04) Average/Hour : 30

Event	Event Count	V Beat Count	% V Beats	% Total Beats	Per 1000	Max Rate (bpm)	Longest (beats / cycles)
VT	0	0	0%	0%	0	-	-
V-Run/AIVR	0	0	0%	0%	0	-	-
IVR	0	0	0%	0%	0	-	-
Triplet	0	0	0%	0%	0	-	-
Couplet	0	0	0%	0%	0	-	-
Bigeminy	0	0	0%	0%	-	-	-
Trigeminy	1	3	<1%	<1%	-	-	2 cycles : Mon 17, 17:23
Single VE Events	916	916	100%	<1%	6	-	-

Supraventricular Arrhythmias

Supraventricular Beats : 14 (<1%) Max/Hour : 4 (Tue 18, 08:00) Max/Minute: 2 (Tue 18, 08:07) Average/Hour : 0

Event	Event Count	SV Beat Count	% SV Beats	% Total Beats	Per 1000	Max Rate (bpm)	Longest (beats)
SVT	0	0	0%	0%	0	-	-
SVE Run	0	0	0%	0%	0	-	-
SVE Couplet	0	0	0%	0%	0	-	-
Single SVE Events	14	14	100%	<1%	0	-	-

Findings :

Indication - Stroke ?pAF

72hr Request(monitor removed early)
poor baseline in parts

Sinus rhythm/sinus tachycardia(gradual onset/offset)/sinus bradycardia
1x Episode of Trigeminy lasting 2 cycles
Occasional isolated unifocal VE's
Negligible isolated SVE's
Longest R-R 1.33s
2x Patient events correlating to sinus rhythm/tachycardia with isolated VE's - No diary available for symptoms

Max HR 138bpm
Mean HR 90bpm
Min HR 61bpm

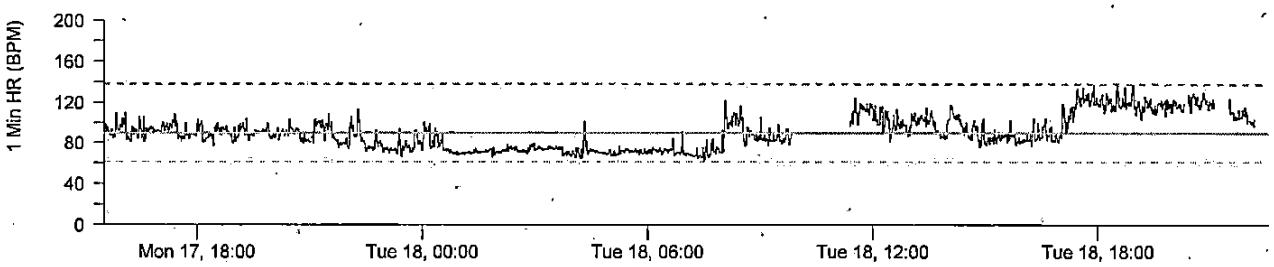
L.Kane

Operator Signature .....

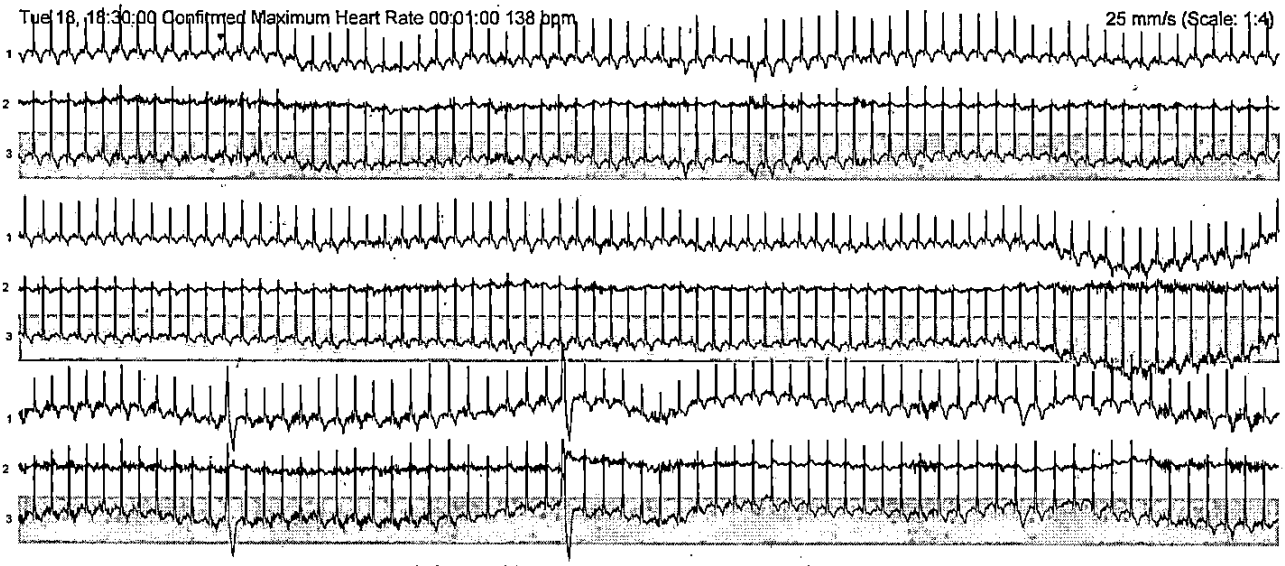
Doctor Signature .....

Signed By: Lisa Kane on 22/04/2025 13:54:34

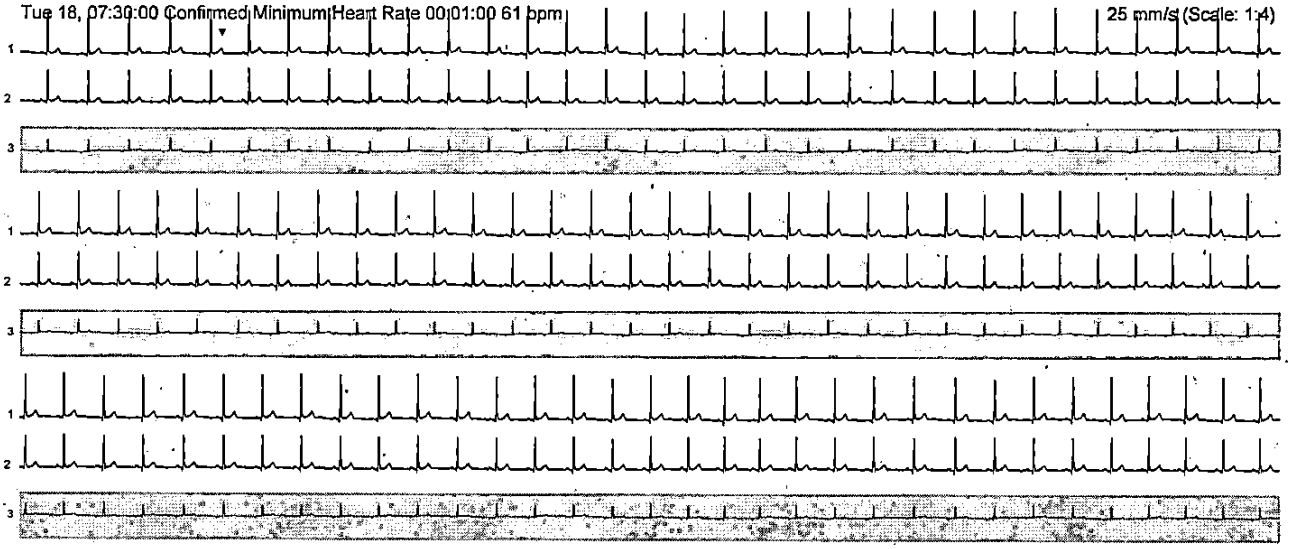
Overall Heart Rate



Maximum Heart Rate Event (1 Minute Avg)



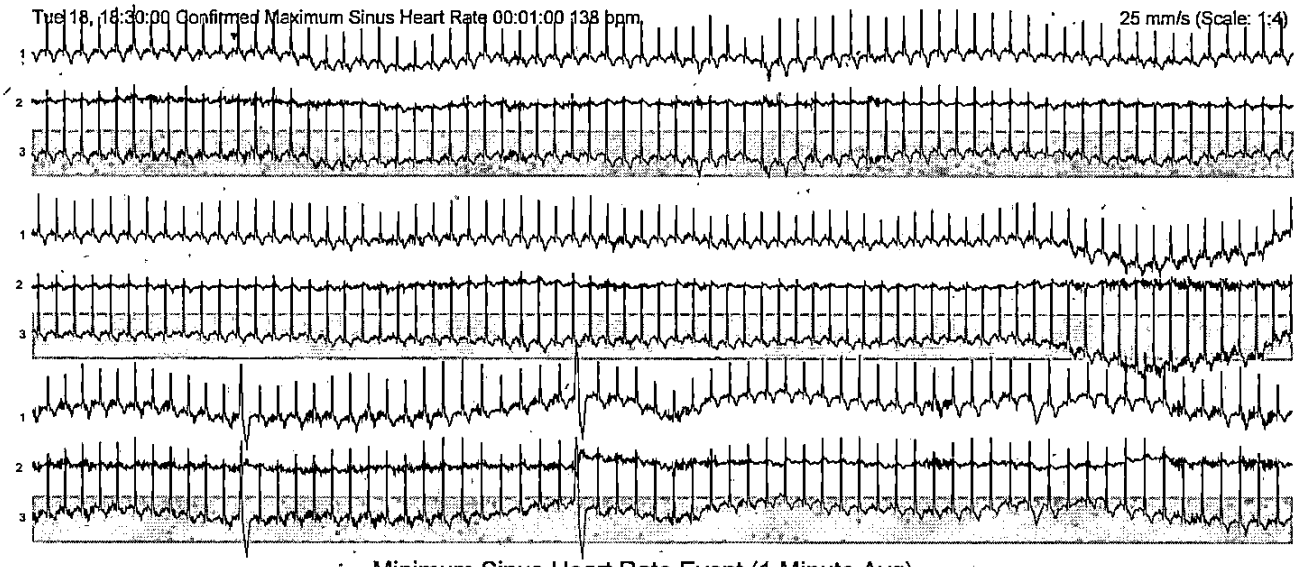
Minimum Heart Rate Event (1 Minute Avg)



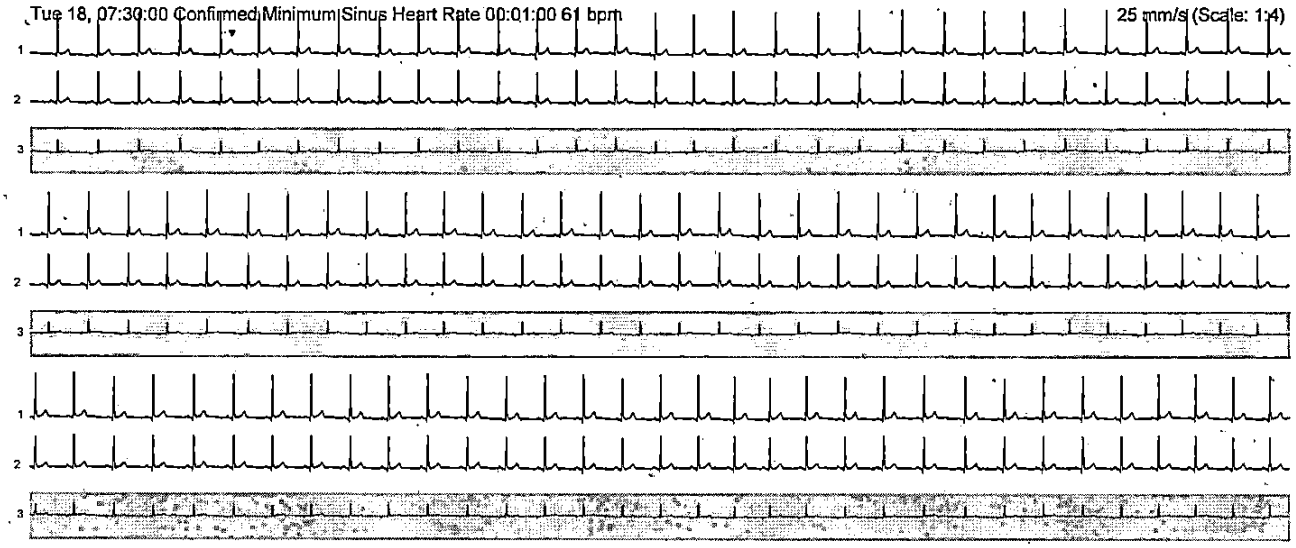
Patient ID: 2504826311 Date of Birth: Sun 25 Apr 1982 (42 years) Gender: Male

Sinus Heart Rate

Maximum Sinus Heart Rate Event (1 Minute Avg)



Minimum Sinus Heart Rate Event (1 Minute Avg)



Signed By: Lisa Kane on 22/04/2025 13:54:34

NHS Greater Glasgow and Clyde

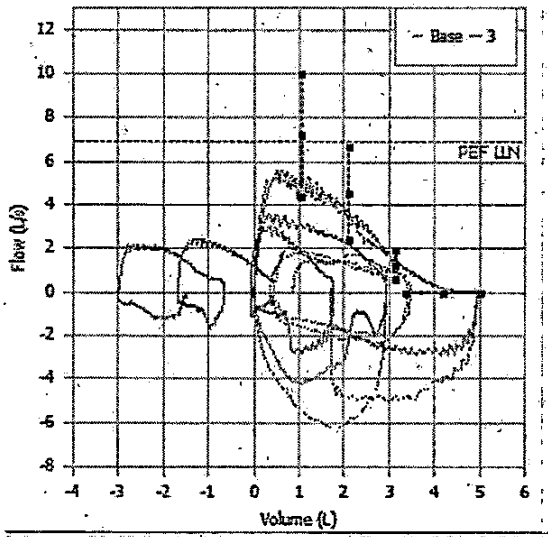
Spirometry Report

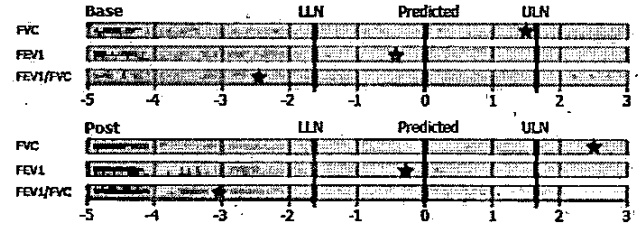
Respiratory Physiology

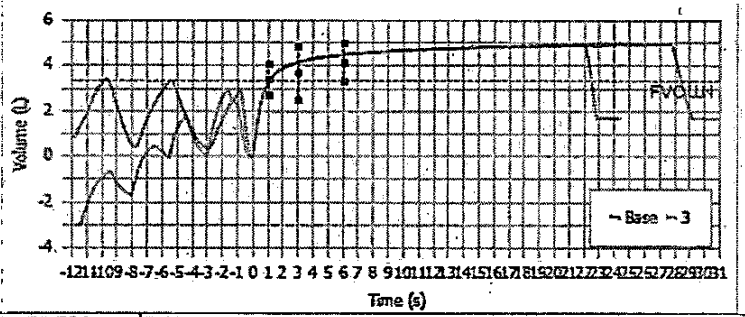
Outreach Post FVC
Subject
2504826311
Neil Cassidy Crawford

GROUP: Outreach | **SITE:** NHSGGC | **PERFORMED:** 09/01/2023 12:13:45 System (SystemUser)

Sex at Birth	Male	**BMI**	27.6	**Drug Name**	Salbutamol
Age	40.70	**Smoking**	Smoker	**Drug Dosage**	2.5 µg
Date of Birth	25/04/1982	**SpO2**	97	**Drug Delivery**	Nebuliser
Population	Caucasian	**MRC**	3	**Base-Test Date**	09/01/2023 12:07:03
Weight	72.4kg; 159.6lb	**Referred By**	GP	**Device Serial**	PN42328
Height	162.0cm; 63.8in	**Predicted Set**	GLI Caucasian		







Values at BTPS	Base				Post				
Parameter	**Best**	**Z-Score**	**Pred**	**%Pred**	**Best**	**Z-Score**	**%Pred**	**Change**	**%Change**
FVC (L)	4.96	1.48	4.18	118.66%	5.49	2.48	131.34%	530 mL	10.69%
FEV1 (L)	3.23	-0.45	3.42	94.44%	3.29	-0.30	96.20%	60 mL	1.86%
FEV1/FVC	0.65	-2.46	0.82	-	0.60	-3.05	-	-	-
FEV1/VC	-	-	0.82	-	-	-	-	-	-
PEF (L/s)	6.54	-1.95	8.83	74.07%	5.97	-2.44	67.61%	-0.57	-8.72%
FEF25-75 (L/s)	1.82	-1.92	3.48	52.30%	1.97	-1.72	56.61%	0.15	8.24%

Session Notes

[09/01/2023 13:59, System] Reduced FEV1/FVC ratio indicates airflow obstruction. Bronchodilator produces no significant response. Results are consistent with COPD Stage 1 (NICE 2010). S Graham/L Speake,
[09/01/2023 12:21, System] 46235 - Smoker - On inhalers but not used today.

SOFTWARE
68800 6.4.50

SIGNATURE .....

DATE .....

PRINTED: 09/01/2023 13:59

ELECTRONIC PATIENT RECORDS

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

Including:

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

Letter to Patient: Follow-up

NHS
Greater Glasgow and Clyde

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER

Main Switchboard: 0141 211 4000
Department: Stroke Department
Contact Tel: 0141 201 3193
Enquiries to:

Neil Cassidy
2/2
14 INGLEBY DRIVE
Glasgow
Lanarkshire
G31 2PT

Letter Date: 02/09/2025
Reference: NO/SM
Dictated Date: 02/09/2025
Transcribed Date: 02/09/2025

Dear Neil ,

As part of the follow-up to your admission under the care of the Stroke Team at Glasgow Royal Infirmary we would like to offer you a review with the Stroke Nurse Specialist Team. The reason for this is just to see how you are and if there is anything you would like to ask us, or any stroke-related problems we can help with.

This review is normally via telephone in the first instance; some people prefer an in-person review which we can also arrange.

If you would like to arrange a review with the team please contact us on 0141 201 3193.

Yours sincerely

Nicola O'Donnell

Stroke Nurse Specialist

Electronically Signed: xxNurse xxNicola xxOdonnell, Nurse

cc.

Clinical letter - GP: Result

NHS
Greater Glasgow and Clyde

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER
Main Switchboard: 0141 211 4000
Department: Stroke Unit, Glasgow Royal Infirmary
Contact Tel: Secretary 0141 451 5197
Enquiries to: Morag Greenlaw

Dr. L Zhang
Townhead Medical Practice
Townhead Health Centre
16 Alexandra Parade
Glasgow
G31 2ES

Letter Date: 29/04/2025
Reference: SI/AF
Dictated Date: 24/04/2025
Transcribed Date: 24/04/2025

Dear Dr Zhang,

Neil Cassidy; D.O.B: 25/04/1982; CHI: 2504826311
2/2, 14 INGLEBY DRIVE, Glasgow, Lanarkshire, G31 2PT

I have been provided with this patients cardiac monitor results. This was reported on the 22nd of April 2025. It shows sinus rhythm/sinus tachycardia/sinus bradycardia. There is no convincing evidence of paroxysmal atrial fibrillation in the context of a recent stroke. The gentleman is currently on Clopidogrel as well as statin and should continue them unchanged for now.

I trust the gentleman will be followed up in the clinic by my colleague Dr Slavin in due course.

Please do not hesitate to get in touch if there were any queries in this regard.

Kind regards.

Yours sincerely

Dr Mohammad Shahzad Iqbal

Locum Consultant Physician

Stroke, Geriatric and General Medicine

GMC: 6048511

Electronically Signed: Dr Mohammad Shahzad Iqbal, Consultant

cc.

Final Discharge Letter

NHS Greater Glasgow and Clyde

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER
0141 211 4000

Dr. L Zhang
Townhead Medical Practice
Townhead Health Centre
16 Alexandra Parade
Glasgow
G31 2ES

Main Switchboard:	
Department:	Acute Stroke Unit
Contact Tel:	Secretary 0141 451 5197
Enquiries to:	morag.greenlaw@nhs.scot
Letter Date:	12/02/2025
Reference:	HS/AF
Dictated Date:	08/02/2025
Transcribed Date:	10/02/2025

Dear Dr. L Zhang,

Neil Cassidy; D.O.B: 25/04/1982; CHI: 2504826311
2/2 14 Ingleby Drive, Glasgow, Lanarkshire, G31 2PT

Admission: Specialty - Geriatric Medicine; Ward - GRI Ward 53 MR D.O.M.E / Stroke Consultant - Dr Helen Slavin; Date of Admission - 05/02/2025
Date of Discharge - 07/02/2025; Discharged to - Private Residence - no additional detail added

Follow Up: Stroke Clinic in 2- 3 months

Clinical Comments:

Clinical Comments:

Dear Dr,

Mr Cassidy was admittd to the GRI 4/2/25 with 5 weeks of intermittent sensory disturbance to the L upper and lower limbs, followed by sudden onset LUQ visual disturbance the night of presentation.

BG: Stage 1 COPD, H Pylori 2017, Anxiety, Cigarette and Cannabis smoker

Investigations:

- ECG NSR

- CTB 4/2/25 showed new SOL R occipital lobe ?malignancy ?CVA

- MRI 6/2/25 Brain showed R occipital infarct in the R thalamus and hippocampus

- CXR 5/2 showed nil of note, formal report awaited

- Bloods were unremarkable, glucose 5.6

- CT Angio showed R PCA occlusion, nil dissection

- Bubble Echo showed normal LV function and normal bubble study

He was treated with Aspirin and commenced statin as per stroke protocol. Mr Cassidy remained well throughout admission although remained aware of his of LUQ visual deficit.

He was reviewed by PT and discharged with follow up noted below. Mr Cassidy experienced high levels of anxiety

throughout his admission and PRN diazepam doses at times.

Medication Changes

- Commenced Atorvastatin 80mg ON

- Commenced Aspirin 300mg OD, to switch to Clopidogrel 75mg OD 20th February as per GGC stroke protocol.

- 5 day supply of PRN Diazepam for anxiety, 2mg BD. For GP to review on discharge, not for ongoing prescription.

Follow up:

- For OPD Stroke with Dr Slavin on discharge +/- CST

Results Awaited

- Lipid profile awaited at time of writing

- Formal CXR report awaited

Thank you for your continued care for this patient,

Kind regards

Ward 53 Drs

Discharge Comments:

Follow Up: Yes

Follow up:

- For OPD Stroke with Dr Slavin on discharge +/- CST

Results Awaited: Yes

Results Awaited

- Lipid profile awaited at time of writing

- Formal CXR report awaited

Pharmacist Comments:

Final Discharge Letter to Follow: Yes

COMMENTS TO BE ADDED TO IMMEDIATE DISCHARGE LETTER: 08.02.25

Diagnosis:

1. MRI confirmed right occipital infarct with no obvious functional impairment at point of discharge

2. No significant extra-cranial vascular disease on CTA carotids - right PCOM occlusion noted

3. Structurally normal heart with no evidence of right to left shunt on bubble echocardiogram

4. Awaits outpatient ambulatory ECG monitor

5. Heavy smoker and cannabis user

Medication on discharge:

As per IDL - please note discharged to complete two weeks of Aspirin 300mg once daily, switching to Clopidogrel 75mg once daily thereafter

Further investigation and follow-up:

Outpatient ambulatory ECG

Clinic follow-up with me in 2-3 months

This 42-year-old gentleman was admitted to Glasgow Royal Infirmary under the care of the Stroke Team. He presented with a five week history of intermittent left-sided sensory motor symptoms and then a two day history of left-sided upper visual field loss.

On initial examination he was noted to have a left superior quadrantanopia but this seemed to improve as his admission progressed. Initial brain imaging with CT showed an area of hypo-attenuation within the right occipital lobe and subsequent MRI confirmed this to be an acute infarct. The rest of his neurovascular investigations to date are as outlined above.

Mr Cassidy did well with a short period of Multi-Disciplinary input. He was very keen for early discharge home from the hospital and we felt it was reasonable to facilitate this on the 7th of February.

He awaits cardiac monitoring and I will be in touch with the result when it becomes available. I will offer him fairly soon clinic follow-up but please don't hesitate to contact me if you have any concerns in the interim.

Routine bloods unremarkable, cholesterol 5.1mmol/L, random glucose normal. Chest x-ray looked clear to my eyes but awaits formal reporting. No incidental findings of note on CTA carotids.

Kind regards.

Yours sincerely

Dr Helen Slavin

Consultant Physician in Stroke Medicine

Electronically Signed: Dr Helen Slavin, Consultant

cc.

Immediate Discharge Letter

NHS Greater Glasgow and Clyde

Highly Sensitive: No
Consent for Sharing Withheld: No

LING ZHANGTownhead Medical Practice,Townhead Health Centre,16 Alexandra Parade, Glasgow, G31 2ES

Main Switchboard:
Date of Completion: 07-Feb-2025

Dear LING ZHANG,

Name	CHI	DoB	Address
Neil Cassidy	**2504826311**	**25-Apr-1982**	**2/2 14 Ingleby Drive, Glasgow, Lanarkshire, G31 2PT**

Admitted	Type	Discharged	Destination
05-Feb-2025 12:56	IP	07-Feb-2025	

Specialty	Consultant	Ward	Telephone
Geriatric Medicine	Slavin	GRI Ward 53 MR D.O.M.E / Stroke	

Primary Diagnosis
There is no data to display.

Secondary Diagnosis
There is no data to display.

Significant Operations / Procedures:
Results Awaited - Lipid profile awaited at time of writing - Formal CXR report awaited

Last Discharge Review: Dorothy Mundt-Leach (Dorothy Mundt-Leach - FY1 Doctor August 2021) on 07 Feb 2025 16:31

Discharge Medication:

Active Drug Name	Route	Dose	Disp	Reason	Further Details	ECS	Since Admission
Aspirin 300mg dispersible tablets	oral	1 tablet once daily at night , Fixed Period 14 Day(s) from 06 Feb 2025	Yes		**Drug Details:** R occipital stroke, 14 days Aspirin then switch to Clopidogrel 75mg OD as per protocol		Added
Atorvastatin 80mg tablets	oral	1 tablet once daily at night	Yes				Added
Clopidogrel 75mg tablets	oral	1 tablet once daily , On-going from 20 Feb 2025	Yes		**Drug Details:** R occipital stroke, 14 days Aspirin 300mg then switch to Clopidogrel 75mg OD as per protocol		Added
Diazepam 2mg tablets	oral	1 tablet twice daily when required , Fixed Period 5 Day(s) from 07 Feb 2025			**Drug Details:** For anxiety following hospital admission, GP to review. 2mg BD 5 days supply.		Added

"Added" means this medicine was added to the Clinical Portal record after admission. It does not necessarily mean this medicine was started by the hospital.

Dispensing Comments
There is no data to display.

Withheld Medication:

Date	Withheld Drug Name	Route	Dose	Note	Withheld Reason
There is no data to display.					

Stopped Medication:

Date	Stopped Drug Name	Route	Dose	Note	Stopped Reason
There is no data to display.					

Reason for Admission and Presenting Complaints	Admission Category
No data available	No data available

Clinical Comments:	
	Dear Dr, Mr Cassidy was admittd to the GRI 4/2/25 with 5 weeks of intermittent sensory disturbance to the L upper and lower limbs, followed by sudden onset LUQ visual disturbance the night of presentation. BG: Stage 1 COPD, H Pylori 2017, Anxiety, Cigarette and Cannabis smoker Investigations: - ECG NSR - CTB 4/2/25 showed new SOL R occipital lobe ?malignancy ?CVA - MRI 6/2/25 Brain showed R occipital infarct in the R thalamus and hippocampus - CXR 5/2 showed nil of note, formal report awaited - Bloods were unremarkable, glucose 5.6 - CT Angio showed R PCA occlusion, nil dissection - Bubble Echo showed normal LV function and normal bubble study He was treated with Aspirin and commenced statin as per stroke protocol. Mr Cassidy remained well throughout admission although remained aware of his of LUQ visual deficit. He was reviewed by PT and discharged with follow up noted below. Mr Cassidy experienced high levels of anxiety throughout his admission and PRN diazepam doses at times. Medication Changes - Commenced Atorvastatin 80mg ON - Commenced Aspirin 300mg OD, to switch to Clopidogrel 75mg OD 20th February as per GGC stroke protocol. - 5 day supply of PRN Diazepam for anxiety, 2mg BD. For GP to review on discharge, not for ongoing prescription. Follow up: - For OPD Stroke with Dr Slavin on discharge +/- CST Results Awaited

	- Lipid profile awaited at time of writing - Formal CXR report awaited Thank you for your continued care for this patient, Kind regards Ward 53 Drs
Discharge Comments:	
Follow Up:	Yes Follow up: - For OPD Stroke with Dr Slavin on discharge +/- CST
Results Awaited:	Yes Results Awaited - Lipid profile awaited at time of writing - Formal CXR report awaited
Pharmacist Comments:	
Final Discharge Letter to Follow:	Yes

Yours sincerely,

Dorothy MUNDT-LEACH

Prescription Review
Checked by: Dorothy MUNDT-LEACH (FY1 Doctor August 2021)
Discharged by: Dorothy MUNDT-LEACH (FY1 Doctor August 2021)

Emergency Attendance Letter

NHS
Greater Glasgow and Clyde

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

Dept. Contact Details:
Tel:
Fax:
Email:

Date Completed: 29/09/2020

Consultant: Dr Donogh Maguire

S Lateef
Forge Medical Practice
Parkhead Health Centre
101 Salamanca Street
Glasgow
Glasgow
G31 5BA

Dear S Lateef

Re: **Cassidy Crawford Neil** DOB: **25/04/1982** CHI: **2504826311**
2/2 14 Ingleby Drive
Glasgow G31 2PT

Attended on: **29/09/2020 at 09:16 hrs.** Departed on: **29/09/2020 at 09:48 hrs.**
Discharge Type: **01a - Discharge with no follow up** Destination: **Private residence**
Previous ED Attendance in last 12 months: **0**

Presenting complaint
back inj

Nursing Assessment:

Investigations in ED: **None**

Diagnosis:

Diagnosis	Side	Site
Sciatica		**Back**

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:

***No GP action required* Sudden onset LBP after lifting a sofa yesterday. Reports intermittent left leg pain but denies any red flags. On examination there was reduced lumbar ROM and left SLR was positive at 45 degrees. All hard-neuro testing was normal. Imp: LBP and referred leg pain. Discharged with advice and exercises. Worsening advice given.**

Followup :

Highly sensitive: N Consent for sharing withheld: N

Yours sincerely,
Elaine Urquhart
Physiotherapist

Copies to:

1. S Lateef (GP)

School Address:

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

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

Dept. Contact Details:
Tel:
Fax:
Email:

Date Completed: 04/08/2014

Consultant: Dr Claire Fitzpatrick

AG Rollo
Townhead Medical Practice
Townhead Health Centre
16 Alexandra Parade
Glasgow
Glasgow
G31 2ES

Dear AG Rollo

Re: **Cassidy Neil** DOB: **25/04/1982** CHI: **2504826311**
3/1 1361 Duke Street
Glasgow G31 5PN

Attended on: **04/08/2014 at 09:35 hrs.** Departed on: **04/08/2014 at 11:52 hrs.**
Discharge Type: **01a - Discharge with no follow up** Destination: **Private residence**
Previous ED Attendance in last 12 months: **0**

Presenting complaint
fall-head,ribs injury

Nursing Assessment:
Fall 3/7, landed left side of ribs, increased pain since. No sputum/SOB/haemoptysis, laos banged top of forehead, small bruise noted, denies LOC

Investigations in ED: **None**

Diagnosis:

Diagnosis	Side	Site
Fracture of rib, closed	**Left**	

Procedures: **None**

Immunisations: **None**

Dispensed Medication:

Dispensed Medicine	Formulation	Dose	UOM	Route	Frequency	Duration
Cocodamol 30/500 2 tabs QID PREPACKED ONLY	**Tablets (PP)**	**2**	**TABS**	**Oral**	**FOUR Times a Day**	**No duration defined**

Clinician Notes:

Incentally commented on blackouts which he has been having for sometime, the last one being over a month ago. Says that he wonders if this is related to a head injury which he sustained 5 years ago. In view of the prolonged period of this problem I think it would be best investigated as an out patient and would be obliged if he could be referred.

Followup : **GP**

Highly sensitive: N Consent for sharing withheld: N

Yours sincerely,
John Burns
Doctor

Copies to:

1. AG Rollo (GP)

School Address:

HOSPITAL INFORMATION MISSING

Dr MUHAMMAD RASHID
12/14 TULLIS STREET
GLASGOW

G40 1HN

Date : 09 Sep 2010

Dear Dr MUHAMMAD RASHID,

Re: NEIL CASSIDY, HOUSE 16, 40 ROSEMOUNT STREET, GLASGOW, G21 2JP
Date of Birth: 25/04/1982 CHI number: 2504826311

HOSPITAL INFORMATION MISSING Patient attended on the 09 Sep 2010.

The presenting complaint was:	**HEAD PAIN**
Triage information:	**SUSTAINED A HEAD INJURY LAST YEAR TODAY CO OF ONGOING HEADACHES AND STATES HE COLLAPSED LAST GCS 15**
The following investigations were carried out:	**None**
The A&E diagnosis was:	**NONE ASSIGNED IN EDIS**
The following treatment was given:	**None**

At the conclusion of treatment the patient was: **PATIENT LEFT BEFORE ASSESSMENT COMPLETE**

Follow-up: **NOT KNOWN**

Additional information: **None**

Yours sincerely,

CLAIRE FITZPATRICK

CONSULTANT IN EMERG. MEDICINE

Glasgow Royal Infirmary

CHI: 2504826311

Total Att: **5**

12 Mth Att: **0**

Title: **MR**

CASSIDY CRAWFORD **Neil**

DOB **25/04/1982** Age: **38y** Sex: **Male**

2/2 14 Ingleby Drive

Glasgow
G31 2PT
07731855475

Next of kin: **CRAWFORD, Kellyann**
Relationship: **Sister**

GP: **S Lateef**
0141 531 9050

Attendance Date: **29/09/2020** Arrival Time: **09:16**

Registration Time: **09:16** Date of Incident: **29/09/2020**

Major Incident Desc:

Reason for Attendance: **back inj**

Nursing Assessment

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

Triage Category: **0** Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: **29/09/2020 09:19** Nurse name: **Physiotherapist Elaine Urquhart**

Temp		C
HR		bpm
BP	/	mmHg
MAP		mmHg
RR		bpm
SpO2		%
Oxygen		%

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

Visual Acuity	
Left	
Right	
Corrected?	

GCS	
Eyes	
Motor	
Verbal	
Total	

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

Nursing Notes:

Neil Cassidy Crawford CHI 2504826311 (2)

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

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

Date	Clinical Notes
	Seen By E.Urquhart PT — Time Seen 09:25
29/9/20	P.C 38 yr old (N) C LBP + (R) leg pain
	H.P.C Sudden onset (R) sided LBP yesterday -> lifting sofa + twisted to (R) side -> worsening + C10 I/M (R) leg pain ∴ MW
	P.M.H Mental health
	S.H Unemployed Lives alone .. 2nd EE
	D.H Mirtazapine Propanolol
	NKOA
O/E	Obs: Guarded posture + TESTore otherwise NAD
	Palp: T.O.P (R) Paraspinals
	NBT L-spine
	RF's ϕ P+N ϕ N/Numb ϕ B/Bowel ϕ Saddle ϕ Unwell ϕ abdo pain
	(PA) Constant ache C I/M Sharp Severe
	(PB) I/M (R) leg pain
	PA > PB
	E.Urquhart PT

Once Only Prescriptions (Including Tetanus Prophylaxis)

Date Given	Drug (Block capitals)	Dose	Method of Administration	Time of Administration	Signature	Given By
29/9/20	Co-codamol	30/500	ORAL	TTO Pack		

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☐
NURSING ☐

Please tick ✔ appropriate directorate

(3)

Neil Cassidy Crawford
CHI 2504826311

Date & Time	Cont.	Signature, Print Name & Designation
29/9/20	Lx AROM	
	Flex Fingertips knee TPA RSF: knee TPA	
	Ext 3/4 TPA LSF: mid thigh TPA	
	SLR (R) 80° TPA (L) 45° +ve P(A) + P(B)	
	Hip ✓✓ (R) = (L)	
	Neuro - Myo (N) R=L	
	Derm (N) R=L	
	Refl Patella/Achilles (N) R=L	
	Babinski -ve (R) = (L)	
	Imp: Sciatica - Nil RF'S	
Rx/	Advice re: Sx + Mx incl heat/Analgesia	
	HEP - Contne AROM as pain allows - SF + knee rolls	
A/	worsening advice given	
p/	D/C'd	E Urquhart

83949 GGC0072

CHI: 2504826311

Glasgow Royal Infirmary

(17) led seats

Total Att: **4**

12 Mth Att: **0**

Title: **MR**

CASSIDY **Neil**

DOB: **25/04/1982** Age: **32y** Sex: **Male**

3/1 1361 Duke Street
Glasgow
G31 5PN
07787636304

Next of kin: **CRAWFORD, Kellyann**
Relationship: **Sister**

GP: **AG Rollo**
0141 531 8945

Attendance Date: **04/08/2014** Arrival Time: **09:35**

Registration Time: **09:35** Date of Incident: **04/08/2014**

Major Incident Desc:

Reason for Attendance: **fall-head,ribs injury**

Nursing Assessment

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

Triage Category: **4** Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: **04/08/2014 09:38** Nurse name: **Nurse Andrew McCulloch2**

Temp	36.2	C
HR	72	bpm
BP	125/72	mmHg
MAP		mmHg
RR	15	bpm
SpO2	99%	(RA)
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: **Fall 3/7, landed left side of ribs, increased pain since. No sputum/SOB/haemoptysis, laos banged top of forehead, small bruise noted, denies LOC**

2504826311 25/04/1982 CASSIDY Neil
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2504826311 25/04/1982 CASSIDY Neil

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

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

Date	Clinical Notes
4/4/14	Seen By JBURNS Time Seen

Fell on stairs while intoxicated Sat night → Scan am. Went down ~9 steps. Struck head, chest + (R) knee Short LOC. °headache ± N+V since % pain on (L) side of chest on moving ↑ etc. °SOB.
Smoker
Also mentioned history of blackouts since head injury. Last one ~1 month ago → to discuss with GP re OP investigation

GCS 15 : PERLA TMs (N)
I - not tested. Power + tone (L) = (R)
II - intact. Bruised abrasion mid forehead
Neck non tender
Tender over (L) 6th rib RS - vesicular + ↓ (L) = (R)
HS I + II + ↓
Bruise on (R) knee - full ROM.
Prob Probable rib #
→ Cocodamol 30/500mg 1-2 tab QID PRN
JBurns.

Once Only Prescriptions (Including Tetanus Prophylaxis)

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

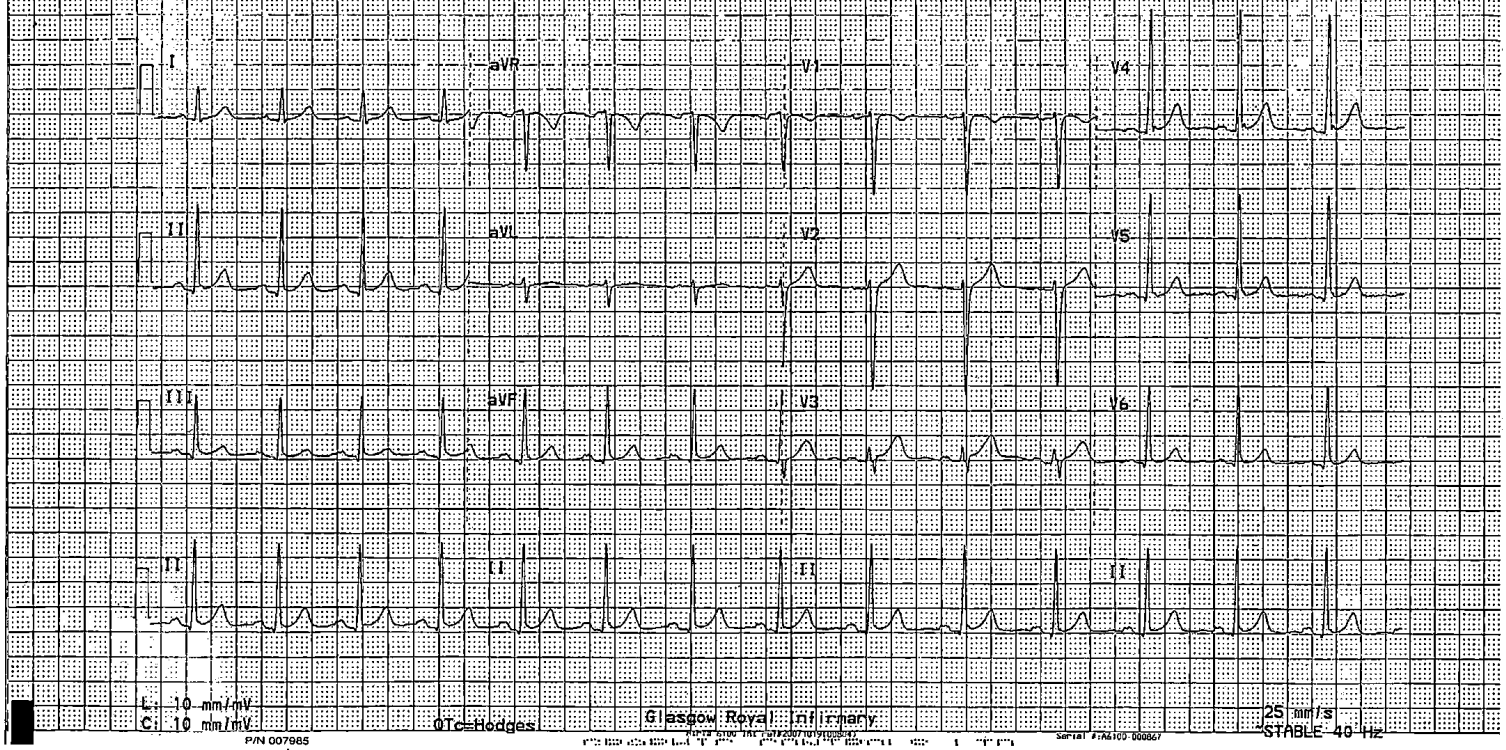
Cassidy,Neil 04.08.2014 11:20:42 Sinus rhythm.

ID: 2504826311 Normal ECG * Unconfirmed Analysis *

MALE
Dept: 201
Tech: 230

2504826311
CASSIDY M
Neil 25/04/1982
3/1 1361 Duke Street
Glasgow
G31 5PN

Vent. Rate:	86	bpm
RR Interval:	694	ms
PR Interval:	160	ms
QRS Duration:	92	ms
QT Interval:	344	ms
QTc Interval:	389	ms
QT Dispersion:	28	ms
P-R-T AXIS:	64°	71° 53°



L: 10 mm/mV
C: 10 mm/mV
QTc=Hodges
Glasgow Royal Infirmary
25 mm/s
STABLE 40 Hz
P/N 007985

NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

Name
Address
2504826311
CASSIDY M
Neil 25/04/1982
3/1 1361 Duke Street
Glasgow
CHI No. G31 5PN
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.

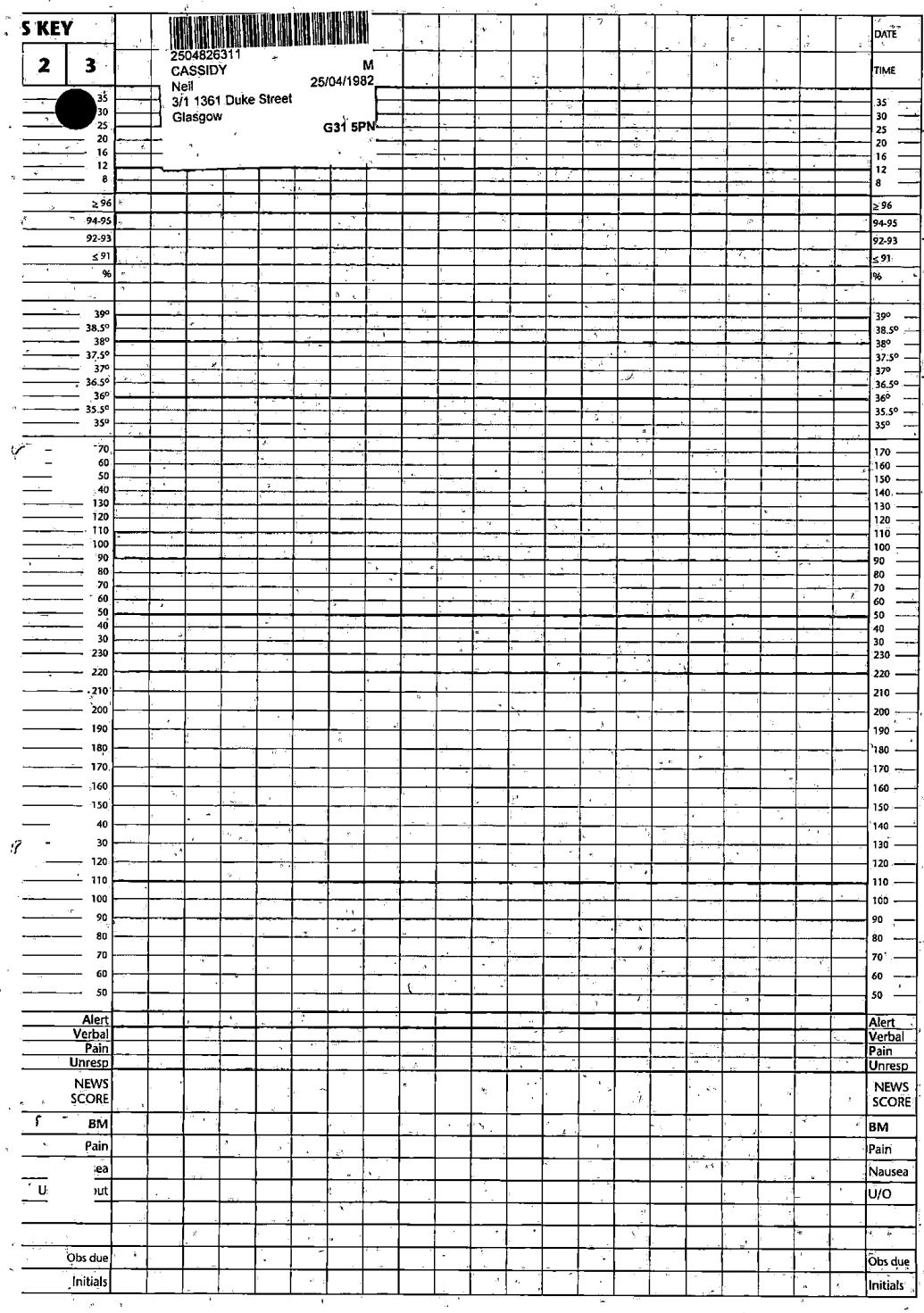
(17)

Neil Cassidy

DATE:		4/8/14	
TIME:		09 35	
Resp. Rate Mark: •	35 / 30 / 25 / 20 / 16 / 12 / 8		
SpO2 (Enter Value)	≥96	99	
	94-95		
	92-93		
	≤91		
Any Sup'l O2	%		
Room air		A	
Temp. Mark: X	39° / 38.5° / 38° / 37.5° / 37° / 36.5° / 36° / 35.5° / 35°		
Pulse Mark: •	170 / 160 / 150 / 140 / 130 / 120 / 110 / 100 / 90 / 80 / 70 / 60 / 50 / 40 / 30		
Blood Pressure Mark: ◇ NEWS SCORE using Systolic BP	230 / 220 / 210 / 200 / 190 / 180 / 170 / 160 / 150 / 140 / 130 / 120 / 110 / 100 / 90 / 80 / 70 / 60 / 50		
Conscious Level Mark: •	Alert / Verbal / Pain / Unresp		
Total NEWS (with all obs)			NEWS SCORE
	BM		BM
	Pain		Pain
	Nausea		Nausea
	Urine output		U/O
	Obs due		Obs due
	Initials		Initials

NEW

0	1


S KEY
2
3
2504826311
CASSIDY
Neil
3/1 1361 Duke Street
Glasgow
M
25/04/1982
G31 5PN
DATE
TIME
Resp. Rate
SpO2
Temp.
Pulse
Blood Pressure
Alert
Verbal
Pain
Unresp
NEWS SCORE
BM
Pain
Nausea
U/O
Obs due
Initials

Neurological Observations

Date:																							
Time:				1115																			
COMA SCALE	Eyes open (E)	Spontaneously	4	o																			Eyes closed by swelling = C
		To speech	3																				
		To pain	2																				
		None	1																				
	Best Verbal response (V)	Orientated	5	o																			Endotracheal tube or tracheostomy = T
		Confused	4																				
		Inappropriate words	3																				
		Incomprehensible sounds	2																				
		None	1																				
	Best motor response (M)	Obeys	6	o																			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		4																			+ reacts – no reaction c. eyes closed
		Reaction		+																			
	L	Size		4																			
		Reaction		+																			
LIMB MOVEMENT	ARMS	Normal power		o																			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		o																			
		Mild weakness																					
		Severe weakness																					
		Spastic flexion																					
		Extension																					
		No response																					

Glasgow Coma Scale

Pupil size (mm)

1
2
3
4
5
6
7
8

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

CT Angio aortic arch and carotid Both

Performed	07-Feb-2025 10:48	Received	07-Feb-2025 12:00
Reported	07-Feb-2025 11:58	Order Number	G107H41885944
Status	Final	Source System	MiSys

CT Angio aortic arch and carotid Both Final
Neil Cassidy
Clinical History :

right occipital infarct with further infarcts thalamus / hippocampus. CTA ? stenosis / dissection

CT Angio aortic arch and carotid Both :
Standard angiogram from arch to vertex. Unremarkable aortic arch and standard arch anatomy. Unremarkable carotid arteries. Dominant left vertebral artery and normal extracranial vertebral arteries. Notably thready right intracranial vertebral artery beyond the PICA origin although this is within the limits of normal variation. There appears to be abrupt occlusion of the right posterior cerebral artery around 5 mm from its origin. Left fetal PCA noted.
Established right occipital infarct.
Prominent adenoidal pad looks benign/reactive. Carious change of the two remaining mandibular teeth. No other head neck findings.

Conclusion: Occluded right PCA.

Reported by: Dr Claire McArthur
Verified by: Dr Claire McArthur

MRI Head

Performed	06-Feb-2025 13:42	Received	06-Feb-2025 14:26
Reported	06-Feb-2025 14:24	Order Number	G107H41880145
Status	Final	Source System	MiSys

MRI Head Final
Neil Cassidy
Clinical History :

bilateral left superior quadrantanopia, rea of hypodensity seen within the right occipital lobe in keeping with space occupying lesion, advised MRI ?SOL

MRI Head :
Right medial occipital infarct as shown on CT. Further areas of infarction are present in the right thalamus and hippocampus which I can not clearly identify on CT from 4-2. No haemorrhage. No substantial background white matter disease. No other findings of note.

Reported by: Dr Leighton Walker
Verified by: Dr Leighton Walker

XR Chest

Performed	06-Feb-2025 11:47	Received	12-Feb-2025 18:23
Reported	12-Feb-2025 18:21	Order Number	G107H41881740
Status	Final	Source System	MiSys

XR Chest Final
Neil Cassidy
Clinical History :

42yo smoker with new neuro symptoms, CTB showed stroke vs. tumour. CXR ? evidence of malignancy

Chest radiograph, PA. Clear lungs and pleural spaces. Normal cardiomediastinal contours.

Reported by: Dr Jonathan Wei Sheng Pang (SpR)
Verified by: Dr Jonathan Wei Sheng Pang (SpR)

CT Head

Performed	04-Feb-2025 23:09	Received	05-Feb-2025 10:11
Reported	05-Feb-2025 10:09	Order Number	G405H41877049
Status	Final	Source System	MiSys

CT Head Final
Neil Cassidy
Clinical History :

p/w 3 days bilateral left superior quadrantanopia
PEARL
no other neurology
sudden onset after a cough
?ICH

CT Head :

****Provisional registrar report, this will be superseded by a verified consultant report ****

Unenhanced CT head. No prior imaging for comparison.

Findings:

Focal area of hypodensity measuring 36x 26x 26mm (AP, TR, CC) seen within the right occipital lobe which abuts the falx cerebri medially and tentorium inferiorly. There is sulcal effacement but no midline shift, uncal or tonsillar herniation. This is likely represents a primary brain malignancy or metastasis with surrounding vasogenic oedema rather than infarct. Recommended post contrast imaging for further evaluation in the first instance.

No acute haemorrhage, extra-axial collection.

No dense vessel.

Area of periventricular low attenuation in keeping with small vessel disease.

Unremarkable appearances of CSF spaces.

Unremarkable appearance of the orbits, paranasal sinuses and mastoid air cells.

The skull and cranio-cervical junction are intact.

Impression:
Area of hypodensity seen within the right occipital lobe in keeping with space occupying lesion. Recommend contrast imaging for further evaluation.

Concern review: Appearances likely reflect right PCA territory infarct. Suggest MRI if safe and suitable.

Reported by: Dr Mark Cairns (SpR) and Dr Richard McDonald
Verified by: Dr Richard McDonald

XR Chest

Performed	15-Aug-2018 13:49	Received	17-Aug-2018 13:30
Reported	17-Aug-2018 13:28	Order Number	G107H34167430
Status	Final	Source System	MiSys

XR Chest Final
Neil Cassidy Crawford
Clinical History :
Smoker with recurrent cough

XR Chest :
Normal heart and mediastinal contour. The lungs are clear and the bony thorax is intact.

Reported by: Dr Colin Noble
Verified by: Dr Colin Noble

Pathfinder SL

Cassidy, Neil

Confirmed

2 Lead Holter Report

Patient ID: 2504826311 Date of Birth: Sun 25 Apr 1982 (42 years) Gender: Male

National ID:
Hospital / Practice:
Referring Doctor: Dr Matthew

Case:
Order:
Ward: wd 53

Recorded: Fri 07/02/2025 13:47:00
Analyzed Length: 2 hr 32 min 39 sec, 0.0% artifact
Analyzed by: Wed 12 Feb 2025

Indications (reason for test) :

stroke ?pauses / arrhythmia

Beats

Beats	Total	Normal		Ventricular		Supraventricular		Paced	
Count	16,066	16,065	>99%	0	0%	1	<1%	0	0%
Max/Hour		6,406	Fri 07, 14:00	0		1	Fri 07, 16:00	0	

Intervals:							
	RR Interval	Longest	774 ms	(Fri 07, 15:38:39)	Shortest	338 ms	(Fri 07, 16:19:36)
	NN Interval	Longest	774 ms	(Fri 07, 15:38:39)	Shortest	381 ms	(Fri 07, 16:17:55)

Heart Rates

Heart Rates (1 min avg)	Rate (bpm)	Time
Max	133	Fri 07, 16:17
Min	93	Fri 07, 15:27
Mean	105	
Mean HR (Day)	105	07:00:00 - 23:00:00
Mean HR (Night)		23:00:00 - 07:00:00

Rate Dependent Events

Rate Dependent Events	Count	Most Severe Rate (bpm)	Longest (beats / secs)
Pause	0	-	-
Dropped Beat		-	-
Bradycardia	0		
Tachycardia	189	157 : Fri 07, 16:16	660 beats : Fri 07, 13:57

Ventricular Arrhythmias

Ventricular Beats : 0 (0%) Max/Hour : 0 Max/Minute: 0 Average/Hour : 0

Event	Event Count	V Beat Count	% V Beats	% Total Beats	Per 1000	Max Rate (bpm)	Longest (beats / cycles)
VT	0	0	0%	0%	0		
V-Run/AIVR	0	0	0%	0%	0		
IVR	0	0	0%	0%	0		
Triplet	0	0	0%	0%	0	-	-
Couplet	0	0	0%	0%	0	-	-
Bigeminy	0	0	0%	0%	-	-	-
Trigeminy	0	0	0%	0%	-	-	
Single VE Events	0	0	0%	0%	0	-	-

Supraventricular Arrhythmias

Supraventricular Beats : 1 (<1%) Max/Hour : 1 (Fri 07, 16:00) Max/Minute: 1 (Fri 07, 16:19) Average/Hour : 0

Event	Event Count	SV Beat Count	% SV Beats	% Total Beats	Per 1000	Max Rate (bpm)	Longest (beats)
SVT	0	0	0%	0%	0		
SVE Run	0	0	0%	0%	0		
SVE Couplet	0	0	0%	0%	0		
Single SVE Events	1	1	100%	<1%	0	-	-

Findings :

72 hour monitor requested, only 2 hours 32 mins recorded - patient discharged.
Patient event button activated on 1 occasion - correlating to sinus tachycardia. No diary available.

Sinus rhythm / sinus tachycardia.

1x SVE seen.
No VEs observed.

Max HR - 133bpm
Mean HR - 105bpm
Min HR - 93bpm

Reported by L.Ross (CP)

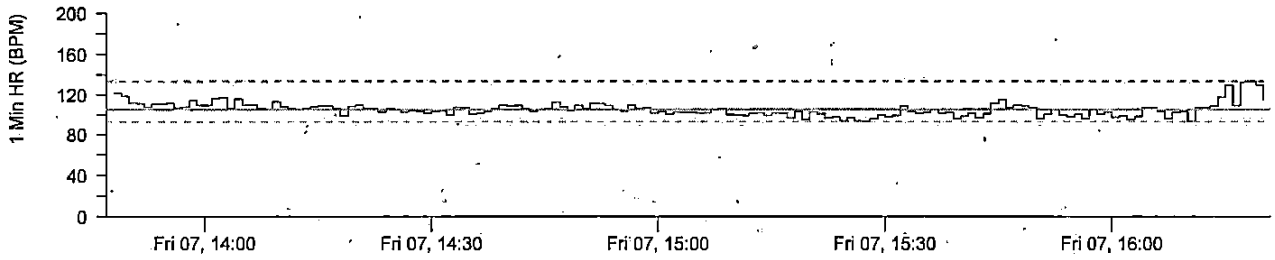
Operator Signature .....

Doctor Signature .....

Signed By: Lauren Ross (GRI) on 12/02/2025 09:08:33

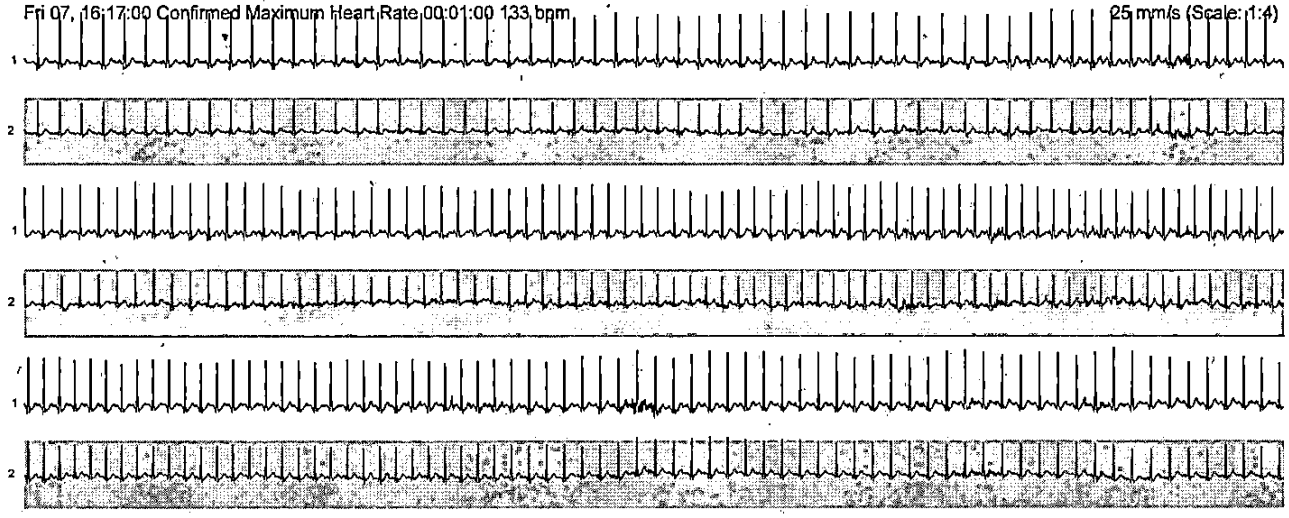
Patient ID: 2504826311 Date of Birth: Sun 25 Apr 1982 (42 years) Gender: Male

Overall Heart Rate



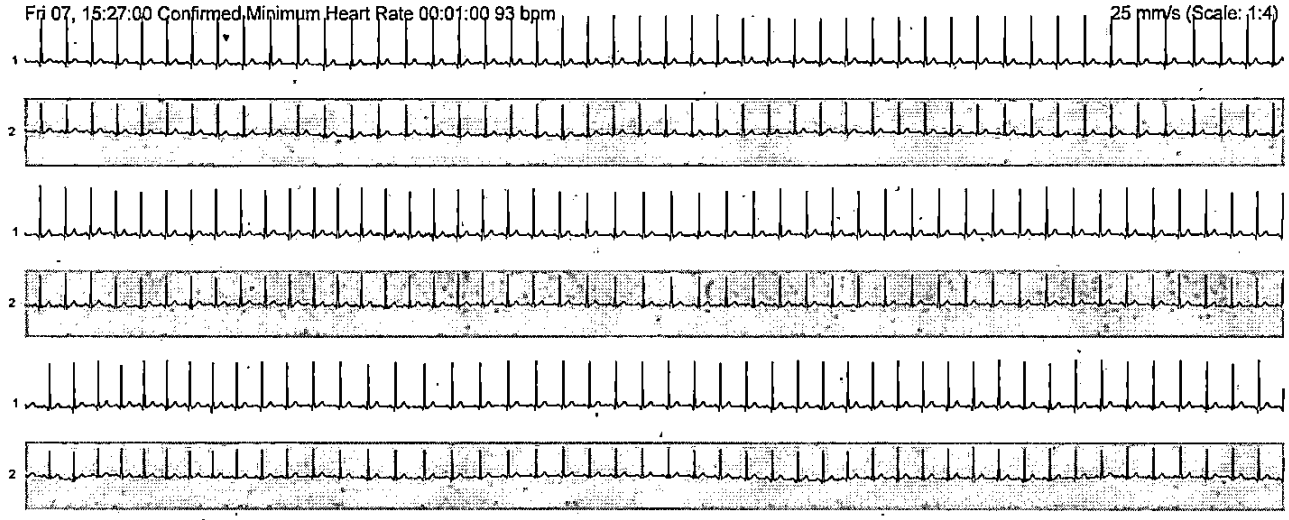
Maximum Heart Rate Event (1 Minute Avg)

Fri 07, 16:17:00 Confirmed Maximum Heart Rate 00:01:00 133 bpm 25 mm/s (Scale: 1:4)



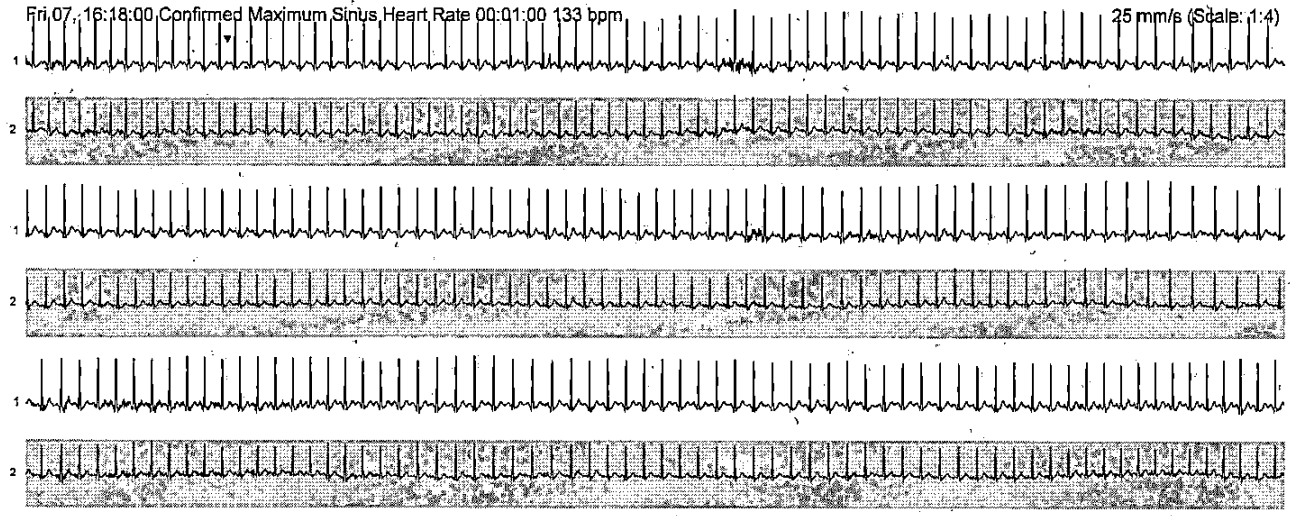
Minimum Heart Rate Event (1 Minute Avg)

Fri 07, 15:27:00 Confirmed Minimum Heart Rate 00:01:00 93 bpm 25 mm/s (Scale: 1:4)

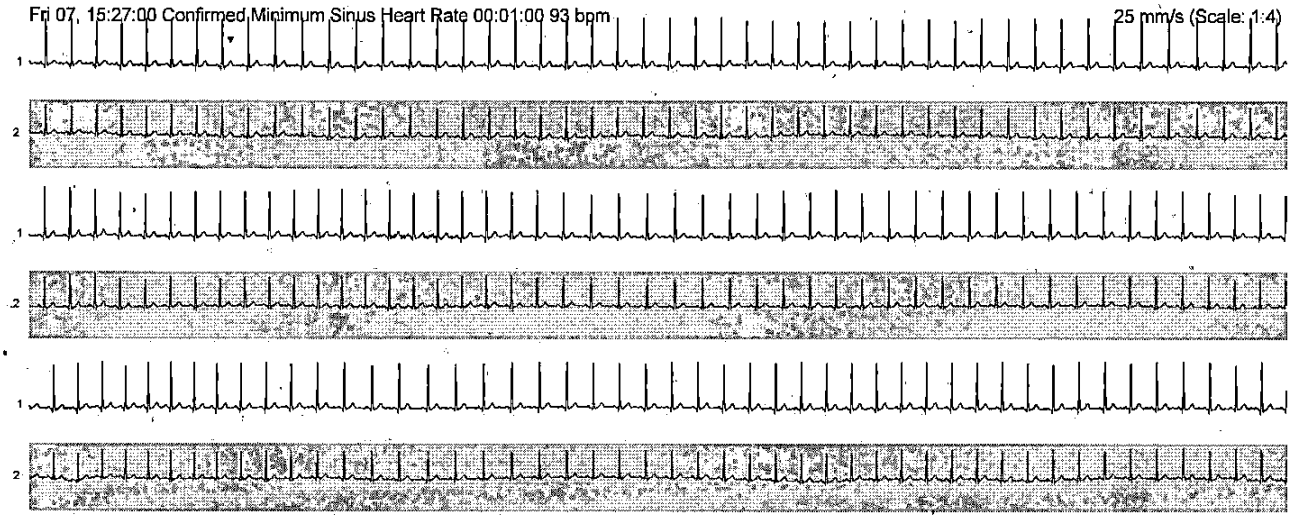


Sinus Heart Rate

Maximum Sinus Heart Rate Event (1 Minute Avg)

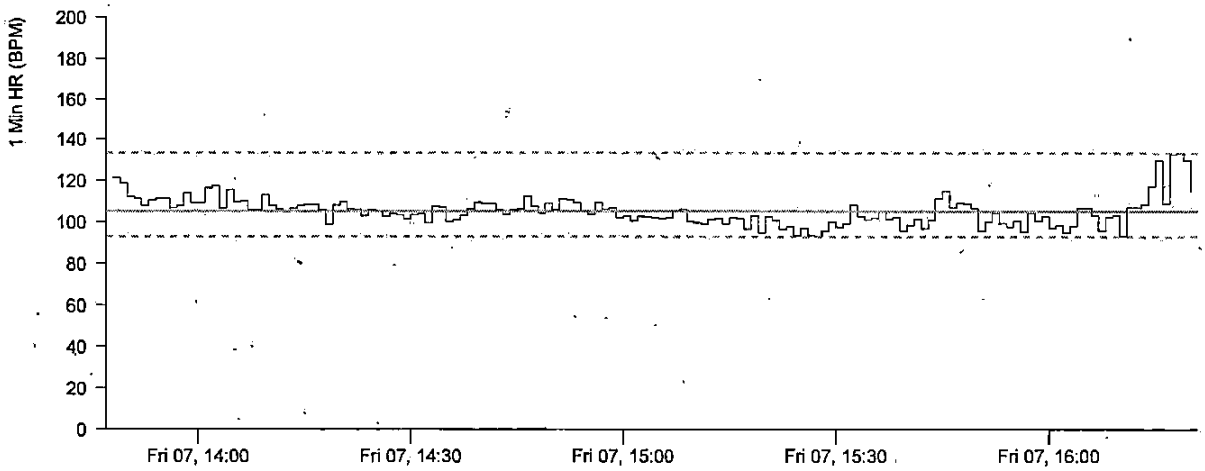


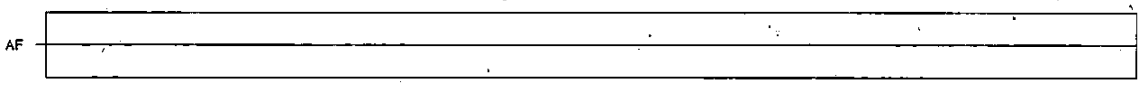
Minimum Sinus Heart Rate Event (1 Minute Avg)

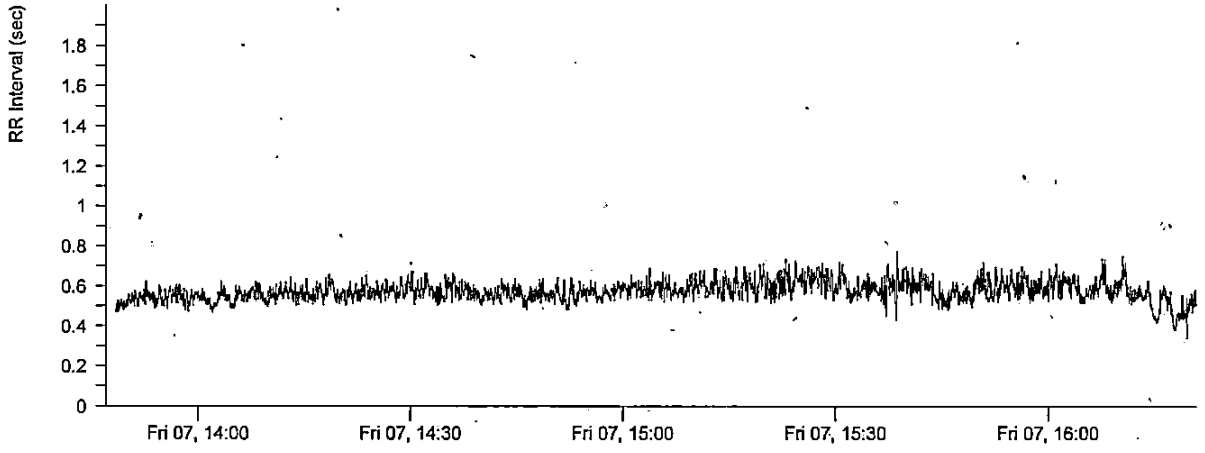


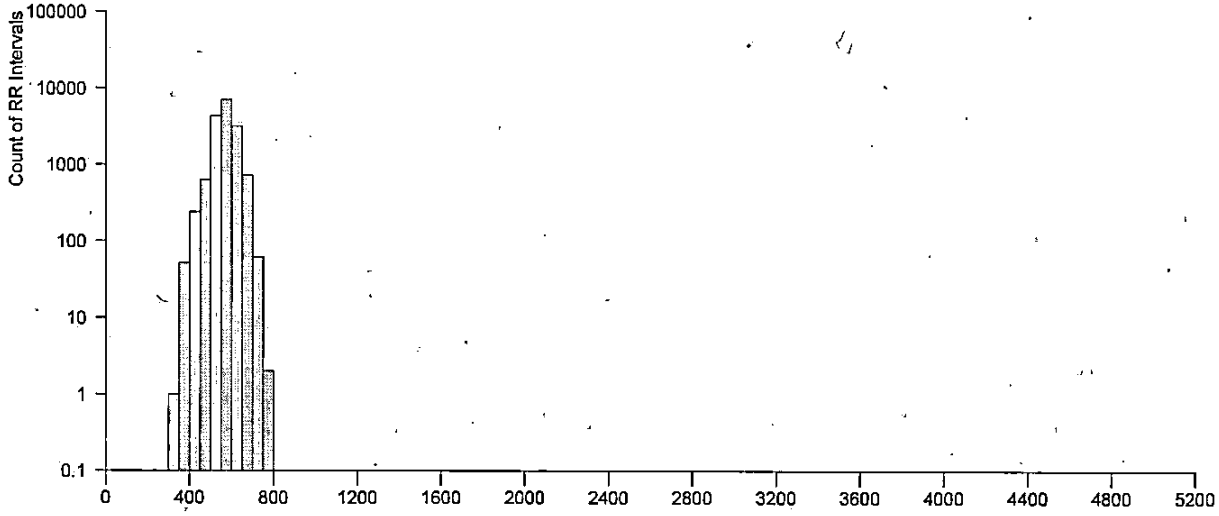
Patient ID: 2504826311 Date of Birth: Sun 25 Apr 1982 (42 years) Gender: Male

Graphs



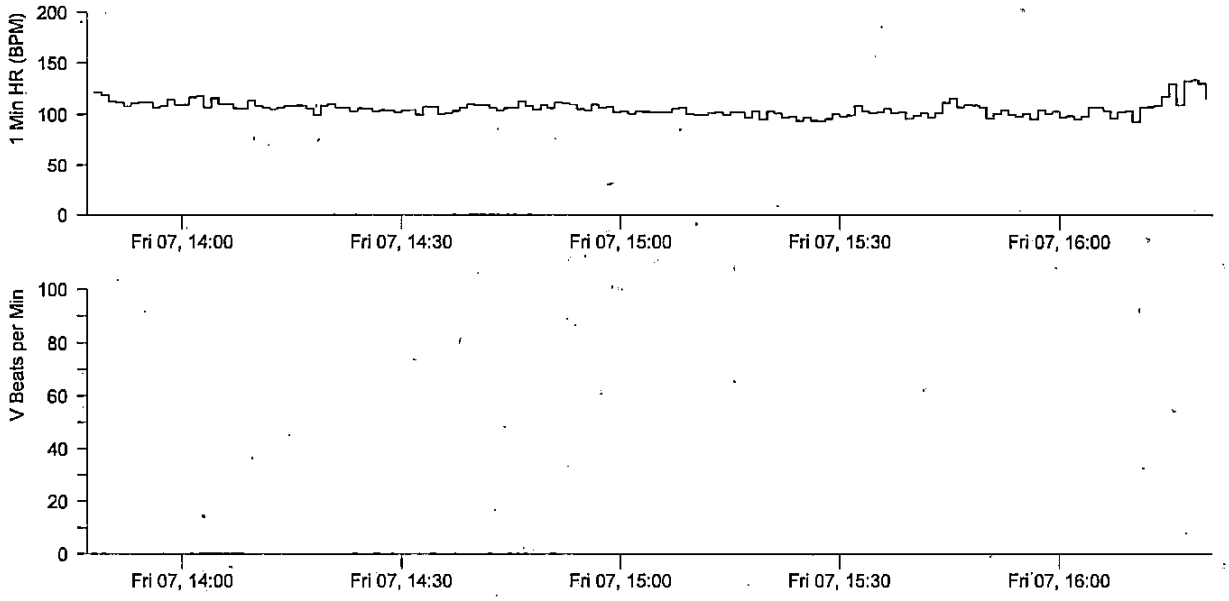






Signed By: Lauren Ross (GRI) on 12/02/2025 09:08:33

Patient ID: 2504826311 Date of Birth: Sun 25 Apr 1982 (42 years) Gender: Male



Signed By: Lauren Ross (GRI) on 12/02/2025 09:08:33

Glasgow Royal Infirmary
Echocardiogram Report

NHS Greater Glasgow and Clyde

Patient Name **Cassidy, Neil** Date of Birth **25/04/1982** Patient Id **2504826311** Sex **Male** **Referred from** wd 53 ip	Date of Exam **07/02/2025** Sonographer **BARCLAY, LISA** Ref. Doc **Slavin** Ward/Dept. **ECG** **Indication:** New stroke bubble study

2D		M-Mode		Doppler	
IVSd	0.9 cm	TAPSE	2.4 cm	LVOT Vmax	1.0 m/s
LVIDd	4.4 cm	IVC exp	1.2 cm	LVOT Vmean	0.7 m/s
LVIDd Index	2.4 cm/m²			LVOT maxPG	4 mmHg
EDV(Teich)	88 ml			LVOT meanPG	2 mmHg
LVPWd	1.0 cm			LVOT Env.Ti	224.6 ms
LVd Mass	159.9 g			LVOT VTI	16.3 cm
LVd Mass Index	86.4 g/m²			LVSV Dopp	55 ml
LVd Mass (ASE)	139.4 g			LVSI Dopp	29.7 ml/m²
LVd Mass Ind (ASE)	75.3 g/m²			AV Vmax	1.1 m/s
RWT	0.44			AV Vmean	0.7 m/s
RV basal	3.1 cm			AV maxPG	5 mmHg
LVOT Diam	2.1 cm			AV meanPG	2 mmHg
Ao Diam SVals	3.0 cm			AV Env.Ti	224.6 ms
SOV indexed	1.844 cm/m			AV VTI	16.3 cm
LA Area	14.2 cm²			AV/LVOT	1.0
RA Area	11.4 cm²			AVA Vmax	3.03 cm²
				AV EOA I Vmax	1.64 cm²/m²
				AVA (VTI)	3.38 cm²
				AV/LVOT	1.00
				DVI	1.00
				MV E Vel	0.7 m/s
				MV DecT	151 ms
				MV Dec Slope	4.8 m/s²
				MV A Vel	0.9 m/s
				MV E/A Ratio	0.8
				MV PHT	44 ms
				MVA By PHT	5.0 cm²
				E' Sept	9.1 cm/s
				E' Lat	14.0 cm/s
				E' Avg	11.5 cm/s
				E/E' Avg	6.3
				PV Vmax	1.5 m/s
				PV maxPG	9 mmHg

Print Date: 07/02/2025

Echo Summary

Adequate scan.
SR

Normal LV cavity size and wall thickness.
Impression of normal LV systolic function
EF by visual assessment 60-65%
E/E' normal

LA and RA are undilated
IAS intact with no obvious colourflow seen across.
Negative bubble study performed by Dr Shah,
No bubbles seen crossing IAS at rest or with VSM

MV leaflets appear normal and open well with no obvious MR detected.

Unable to determine AOV morphology
Leaflets appear normal and open well with no obvious AR detected.
No significant gradient.

Normal proximal ascending aorta and aortic arch appearance.

Pulmonary valve has normal appearance.
No obvious PR detected.

TV has a normal appearance and is seen to open well with trace TR Detected.
Unable to estimate PASP+RAP.

RV is undilated with no obvious impairment.

IVC normal dimensions with repiratory collapse.

Conclusion

Impression of normal LV systolic function
EF by visual assessment 60-65%

Negative bubble study performed by Dr Shah.
No bubbles seen crossing IAS at rest or with VSM

Reported By: L Barclay Senior cardiac physiologist

Urea & Electrolytes View Cumulative Results

Collected	07-Feb-2025 08:12	Received	07-Feb-2025 11:28
Reported	07-Feb-2025 14:27	Order Number	B,25.4375488.S
Status	Final	Source System	Telepath
Comments	REQUESTOR**.		

Test	Result	Ref. Range (Units)	Abnormality
Sodium	137	133 - 146 mmol/L (mmol/L)	
Potassium	4.1	3.5 - 5.3 mmol/L (mmol/L)	
Chloride	105	95 - 108 mmol/L (mmol/L)	
Urea	4.8	2.5 - 7.8 mmol/L (mmol/L)	
Creatinine	67	40 - 130 umol/L (umol/L)	
Estimated GFR	>60	>60 ml/min (ml/min)	

* Abnormal ** Critically Abnormal

Urea & Electrolytes View Cumulative Results

Collected	07-Feb-2025 08:12	Received	07-Feb-2025 11:28
Reported	07-Feb-2025 13:32	Order Number	B,25.4375489.Z
Status	Final	Source System	Telepath
Comments	REQUESTOR**.		

Test	Result	Ref. Range (Units)	Abnormality
Sodium	138	133 - 146 mmol/L (mmol/L)	
Potassium	4.3	3.5 - 5.3 mmol/L (mmol/L)	
Chloride	105	95 - 108 mmol/L (mmol/L)	
Urea	5.0	2.5 - 7.8 mmol/L (mmol/L)	
Creatinine	68	40 - 130 umol/L (umol/L)	
Estimated GFR	>60	>60 ml/min (ml/min)	

* Abnormal ** Critically Abnormal

Transferrin / Iron View Cumulative Results

Collected	07-Feb-2025 08:12	Received	07-Feb-2025 11:28
Reported	07-Feb-2025 13:32	Order Number	B,25.4375489.Z
Status	Final	Source System	Telepath
Comments	REQUESTOR**.		

Test	Result	Ref. Range (Units)	Abnormality
Transferrin	2.94	2.00 - 4.00 g/L (g/L)	
Iron	*** 32**	10 - 30 umol/L (umol/L)	**Abnormal - high**
T'ferrin Saturation	43	25 - 55 % (%)	

* Abnormal ** Critically Abnormal

Thyroid funct test View Cumulative Results

Collected	07-Feb-2025 08:12	Received	07-Feb-2025 11:28
Reported	07-Feb-2025 13:32	Order Number	B,25.4375489.Z
Status	Final	Source System	Telepath
Comments	** Repeat Request ** Following results are from 07.02.25 and are valid for 30 days TSH 0.55 mU/L FreeT4 13.7 pmol/L T3 nmol/L REQUESTOR**.		

Test	Result	Ref. Range (Units)	Abnormality
TSH	NA		
Free T4	NA		
Total T3	NA		

* Abnormal ** Critically Abnormal

Thyroid funct test View Cumulative Results

Collected	07-Feb-2025 08:12	Received	07-Feb-2025 11:28
Reported	07-Feb-2025 14:27	Order Number	B,25.4375488.S
Status	Final	Source System	Telepath
Comments	REQUESTOR**.		

Test	Result	Ref. Range (Units)	Abnormality
TSH	0.55	0.35 - 5.00 mU/L (mU/L)	
Free T4	13.7	9.0 - 21.0 pmol/L (pmol/L)	
Total T3			

* Abnormal ** Critically Abnormal

Magnesium View Cumulative Results

Collected	07-Feb-2025 08:12	Received	07-Feb-2025 11:28
Reported	07-Feb-2025 13:32	Order Number	B,25.4375489.Z
Status	Final	Source System	Telepath
Comments	REQUESTOR**.		

Test	Result	Ref. Range (Units)	Abnormality
Magnesium	0.79	0.70 - 1.00 mmol/L (mmol/L)	

* Abnormal ** Critically Abnormal

Liver Function Tests View Cumulative Results

Collected	07-Feb-2025 08:12	Received	07-Feb-2025 11:28
Reported	07-Feb-2025 14:27	Order Number	B,25.4375488.S
Status	Final	Source System	Telepath
Comments	REQUESTOR**.		

Test	Result	Ref. Range (Units)	Abnormality
Total Bilirubin	13	<20 umol/L (umol/L)	
ALT	21	<50 U/L (U/L)	
AST	21	<40 U/L (U/L)	
Alkaline Phosphatase	104	30 - 130 U/L (U/L)	
Albumin	45	35 - 50 g/L (g/L)	

* Abnormal ** Critically Abnormal

Liver Function Tests View Cumulative Results

Collected	07-Feb-2025 08:12	Received	07-Feb-2025 11:28
Reported	07-Feb-2025 13:32	Order Number	B,25.4375489.Z
Status	Final	Source System	Telepath
Comments	REQUESTOR**.		

Test	Result	Ref. Range (Units)	Abnormality
Total Bilirubin	13	<20 umol/L (umol/L)	
ALT	20	<50 U/L (U/L)	
AST	23	<40 U/L (U/L)	
Alkaline Phosphatase	107	30 - 130 U/L (U/L)	
Albumin	45	35 - 50 g/L (g/L)	

* Abnormal ** Critically Abnormal

Lipid profile View Cumulative Results

Collected	07-Feb-2025 08:12	Received	07-Feb-2025 11:28
Reported	07-Feb-2025 14:27	Order Number	B,25.4375488.S
Status	Final	Source System	Telepath
Comments	REQUESTOR**.		

Test	Result	Ref. Range (Units)	Abnormality
Cholesterol	5.1	(mmol/L)	
Triglycerides	1.5	0.2 - 2.3 mmol/L (mmol/L)	
HDL Cholesterol	1.0	(mmol/L)	
LDL-Cholest (calc'd)	3.4	(mmol/L)	
VLDL-Chol (calc'd)	0.7	(mmol/L)	
Chol/HDL ratio	5.1		

* Abnormal ** Critically Abnormal

C-reactive Protein View Cumulative Results

Collected	07-Feb-2025 08:12	Received	07-Feb-2025 11:28
Reported	07-Feb-2025 13:32	Order Number	B,25.4375489.Z
Status	Final	Source System	Telepath
Comments	REQUESTOR**.		

Test	Result	Ref. Range (Units)	Abnormality
C Reactive Protein	8	0 - 10 mg/L (mg/L)	

* Abnormal ** Critically Abnormal

C-reactive Protein View Cumulative Results

Collected	07-Feb-2025 08:12	Received	07-Feb-2025 11:28
Reported	07-Feb-2025 14:27	Order Number	B,25.4375488.S
Status	Final	Source System	Telepath
Comments	REQUESTOR**.		

Test	Result	Ref. Range (Units)	Abnormality
C Reactive Protein	8	0 - 10 mg/L (mg/L)	

* Abnormal ** Critically Abnormal

Chol/Triglyceride View Cumulative Results

Collected	07-Feb-2025 08:12	Received	07-Feb-2025 11:28
Reported	07-Feb-2025 13:32	Order Number	B,25.4375489.Z
Status	Final	Source System	Telepath
Comments	REQUESTOR**.		

Test	Result	Ref. Range (Units)	Abnormality
Cholesterol	5.2	(mmol/L)	
Triglycerides	1.6	0.2 - 2.3 mmol/L (mmol/L)	

* Abnormal ** Critically Abnormal

Bone Profile View Cumulative Results

Collected	07-Feb-2025 08:12	Received	07-Feb-2025 11:28
Reported	07-Feb-2025 13:32	Order Number	B,25.4375489.Z
Status	Final	Source System	Telepath
Comments	REQUESTOR**.		

Test	Result	Ref. Range (Units)	Abnormality
Calcium	2.44	2.20 - 2.60 mmol/L (mmol/L)	
Calcium (adjusted)	2.41	2.20 - 2.60 mmol/L (mmol/L)	
Phosphate	1.13	0.80 - 1.50 mmol/L (mmol/L)	
Albumin	45	35 - 50 g/L (g/L)	
Alkaline Phosphatase	107	30 - 130 U/L (U/L)	

* Abnormal ** Critically Abnormal

Urea & Electrolytes View Cumulative Results

Collected	04-Feb-2025 22:01	Received	04-Feb-2025 22:54
Reported	04-Feb-2025 23:42	Order Number	B,25.4022883.Y
Status	Final	Source System	Telepath
Comments	REQUESTOR**unwell		

Test	Result	Ref. Range (Units)	Abnormality
Sodium	138	133 - 146 mmol/L (mmol/L)	
Potassium	4.0	3.5 - 5.3 mmol/L (mmol/L)	
Chloride	106	95 - 108 mmol/L (mmol/L)	
Urea	4.4	2.5 - 7.8 mmol/L (mmol/L)	
Creatinine	69	40 - 130 umol/L (umol/L)	
Estimated GFR	>60	>60 ml/min (ml/min)	

* Abnormal ** Critically Abnormal

Liver Function Tests View Cumulative Results

Collected	04-Feb-2025 22:01	Received	04-Feb-2025 22:54
Reported	04-Feb-2025 23:42	Order Number	B,25.4022883.Y
Status	Final	Source System	Telepath
Comments	REQUESTOR**unwell		

Test	Result	Ref. Range (Units)	Abnormality
Total Bilirubin	6	<20 umol/L (umol/L)	
ALT	16	<50 U/L (U/L)	
AST	16	<40 U/L (U/L)	
Alkaline Phosphatase	111	30 - 130 U/L (U/L)	
Albumin	45	35 - 50 g/L (g/L)	

* Abnormal ** Critically Abnormal

Glucose View Cumulative Results

Collected	04-Feb-2025 22:01	Received	04-Feb-2025 22:54
Reported	04-Feb-2025 23:42	Order Number	B,25.4022884.P
Status	Final	Source System	Telepath
Comments	Non-fasting sample REQUESTOR**unwell		

Test	Result	Ref. Range (Units)	Abnormality
Glucose	5.9	3.5 - 6.0 mmol/L (mmol/L)	

* Abnormal ** Critically Abnormal

C-reactive Protein View Cumulative Results

Collected	04-Feb-2025 22:01	Received	04-Feb-2025 22:54
Reported	04-Feb-2025 23:42	Order Number	B,25.4022883.Y
Status	Final	Source System	Telepath
Comments	REQUESTOR**unwell		

Test	Result	Ref. Range (Units)	Abnormality
C Reactive Protein	4	0 - 10 mg/L (mg/L)	

* Abnormal ** Critically Abnormal

Bicarbonate View Cumulative Results

Collected	04-Feb-2025 22:01	Received	04-Feb-2025 22:54
Reported	04-Feb-2025 23:42	Order Number	B,25.4022883.Y
Status	Final	Source System	Telepath
Comments	REQUESTOR**unwell		

Test	Result	Ref. Range (Units)	Abnormality
Bicarbonate	22	22 - 29 mmol/L (mmol/L)	

* Abnormal ** Critically Abnormal

Urea & Electrolytes View Cumulative Results

Collected	29-Nov-2021 10:33	Received	29-Nov-2021 14:24
Reported	29-Nov-2021 16:42	Order Number	B,21.5319968.C
Status	Final	Source System	Telepath
Comments	REQUESTOR**collpase ?cause		

Test	Result	Ref. Range (Units)	Abnormality
Sodium	138	133 - 146 mmol/L (mmol/L)	
Potassium	4.4	3.5 - 5.3 mmol/L (mmol/L)	
Chloride	104	95 - 108 mmol/L (mmol/L)	
Urea	3.7	2.5 - 7.8 mmol/L (mmol/L)	
Creatinine	75	40 - 130 umol/L (umol/L)	
Estimated GFR	>60	>60 ml/min (ml/min)	

* Abnormal ** Critically Abnormal

Thyroid funct test View Cumulative Results

Collected	29-Nov-2021 10:33	Received	29-Nov-2021 14:24
Reported	29-Nov-2021 16:42	Order Number	B,21.5319968.C
Status	Final	Source System	Telepath
Comments	REQUESTOR**collpase ?cause		

Test	Result	Ref. Range (Units)	Abnormality
TSH	2.32	0.35 - 5.00 mU/L (mU/L)	
Free T4	10.7	9.0 - 21.0 pmol/L (pmol/L)	
Total T3			

* Abnormal ** Critically Abnormal

MEDICINE

PRESCRIPTION FORM

Hospital Name: .....

MEDICINES RECONCILIATION

Medicines Reconciled on Admission YES ☐

Date _____ Name (Print) _____

Discharge Prescription Prepared & Reconciled YES ☐

Date _____ Name (Print) _____

Date and time this form prepared: ___/___/___ Time: _____ | Sheet No ..... | 2nd Prescription in use YES ☐ NO ☐

DOCTOR'S DECLARATION (if required by Local Protocol)

I authorise nurse/midwife administration of the medicines included in the symptomatic relief policy & local protocol:

_____

with the following exceptions: _____

Print & Sign: _____ Date: _____

COMMUNITY PHARMACY INFORMATION

Name _____ Tel No. _____

Address _____

Compliance Aid Details _____

Patient consent to share discharge information Y/N

Print & Sign _____

PATIENT DETAILS

H

D

A

2

Da

Co

2504826311 M

CASSIDY 25/04/1982

Neil

2/2 14 Ingleby Drive

Glasgow, Lanarkshire G31 2P

Height:

Weight:

Surface area:

Ward:

ONCE ONLY AND PREMEDICATION DRUGS

DATE	DRUG	DOSE	ROUTE	TIME (24hr)	PRESCRIBER (PRINT & SIGN)	GIVEN BY	TIME GIVEN (24hr)
	COCODAMOL	(30/500) 2	O			JM	0005
	ONDANSETRON	4mg	O			JM	0005

TARGET OXYGEN SATURATIONS

Please CIRCLE a target saturation and prescribe oxygen on the Regular Prescription section.

94 – 98%	88 – 92% (e.g. in hypercapnic respiratory failure)	Other (please specify)

On Home Oxygen? Yes / No _____ L/min

DATE: ___/___/___ PRESCRIBER (PRINT & SIGN): _____

DATE
MONTH

IS DRUG THROMBOPROPHYLAXIS INDICATED? Y / N

ARE ANTIEMBOLISM STOCKINGS INDICATED? Y / N

SIGNATURE OF ASSESSOR

ARE ANTIEMBOLIC STOCKINGS ON PATIENT?
RECORD DAILY AT 1800 DRUG ROUND WITH Y OR N

RECORD OF THROMBOPROPHYLAXIS ASSESSMENT (IN EACH CASE RECORD WITH Y OR N - REASSESS NEED AT LEAST EVERY 48 HRS)

Parenteral Drugs : Regular Prescription

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐	**A** DRUG	DOSE	ROUTE	DATE	STOPPED DATE: INITIALS:
	PRESCRIBER (PRINT & SIGN)				
	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐	**B** DRUG	DOSE	ROUTE	DATE	STOPPED DATE: INITIALS:
	PRESCRIBER (PRINT & SIGN)				
	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐	**C** DRUG	DOSE	ROUTE	DATE	STOPPED DATE: INITIALS:
	PRESCRIBER (PRINT & SIGN)				
	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				

	Patient's Own Medicine	For Use Y/N	Qty:	Date:	Assessed by:	Ordered from Pharm.
Other time						
0700-0900						
1200-1400						
1600-1800						
2200-2400						
Other time						

REVIEW THE NEED FOR IV ANTIBIOTIC DAILY. SWITCH TO ORAL THERAPY AS SOON AS POSSIBLE (SEE IVOST POLICY)

[redacted]

Parenteral Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

D DRUG

DOSE | ROUTE | DATE

PRESCRIBER (PRINT & SIGN)

STOPPED DATE: INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

E DRUG

DOSE | ROUTE | DATE

PRESCRIBER (PRINT & SIGN)

STOPPED DATE: INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

F DRUG

DOSE | ROUTE | DATE

PRESCRIBER (PRINT & SIGN)

STOPPED DATE: INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

G DRUG

DOSE | ROUTE | DATE

PRESCRIBER (PRINT & SIGN)

STOPPED DATE: INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

Patient's Own Medicine
For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

H

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

DRUG
DOSE | ROUTE | DATE
PRESCRIBER (PRINT & SIGN)
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY
STOPPED DATE: INITIALS:

J

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

DRUG
DOSE | ROUTE | DATE
PRESCRIBER (PRINT & SIGN)
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY
STOPPED DATE: INITIALS:

K

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

DRUG
DOSE | ROUTE | DATE
PRESCRIBER (PRINT & SIGN)
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY
STOPPED DATE: INITIALS:

L

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

DRUG
DOSE | ROUTE | DATE
PRESCRIBER (PRINT & SIGN)
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY
STOPPED DATE: INITIALS:

Note: To discontinue a prescription, initial and date appropriate boxes, draw a diagonal line through section & record reason

[redacted]

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

M DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

N DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

P DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

R DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time

Patient's Own Medicine | For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

S

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

DRUG | DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

T

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

DRUG | DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

V

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

DRUG | DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

W

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

DRUG | DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Note: To discontinue a prescription, initial and date appropriate boxes, draw a diagonal line through section & record reason

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time

Patient's Own Medicine | For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

X DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

Y DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

AA DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

BB DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

Oral and Other Drugs: Regular Prescription

DATE
MONTH

Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time

Patient's Own Medicine | For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

CC DRUG

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

DD DRUG

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

EE DRUG

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FF DRUG

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Note: To discontinue a prescription, initial and date appropriate boxes, draw a diagonal line through section & record reason

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

GG DRUG

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

HH DRUG

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

JJ DRUG

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

KK DRUG

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

All Routes: As Required Prescriptions

Patient's Own Medicine

BEFORE ADMISSION ☐	LL	DRUG: Paracetamol		STOPPED DATE:	DATE	5/2
	DOSE: 1g	ROUTE: PO	INDICATION: PAIN / TO	INITIALS:	TIME	08 / 18
NEW DOSE ☐	PRESCRIBER (PRINT & SIGN): [signature]		MAX.FREQ.: 4°	DATE: 5/2	DOSE	1g
NEW MEDICATION ☐	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				GIVEN BY	SP

For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

BEFORE ADMISSION ☐	MM	DRUG: Dihydrocodeine		STOPPED DATE:	DATE	5/2
	DOSE: 30-60mg	ROUTE: PO	INDICATION: PAIN	INITIALS:	TIME	08 / 18
NEW DOSE ☐	PRESCRIBER (PRINT & SIGN): [signature]		MAX.FREQ.: 4°	DATE: 5/2	DOSE	30 mg
NEW MEDICATION ☐	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				GIVEN BY	SP

For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

BEFORE ADMISSION ☐	NN	DRUG: ondansetron		STOPPED DATE:	DATE	5/2
	DOSE: 4mg	ROUTE: PO/IV	INDICATION: N+V	INITIALS:	TIME	07
NEW DOSE ☐	PRESCRIBER (PRINT & SIGN): [signature]		MAX.FREQ.: 8°	DATE: 5/2	DOSE	4mg
NEW MEDICATION ☐	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				GIVEN BY	

For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

BEFORE ADMISSION ☐	PP	DRUG:		STOPPED DATE:	DATE	
	DOSE:	ROUTE:	INDICATION:	INITIALS:	TIME	
NEW DOSE ☐	PRESCRIBER (PRINT & SIGN):		MAX.FREQ.:	DATE:	DOSE	
NEW MEDICATION ☐	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				GIVEN BY	

For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

Note: To discontinue a prescription, initial and date appropriate boxes, draw a diagonal line through section & record reason

BEFORE ADMISSION ☐	RR	DRUG			STOPPED DATE:	DATE
	DOSE	ROUTE	INDICATION		INITIALS:	TIME
NEW DOSE ☐	PRESCRIBER (PRINT & SIGN)			MAX.FREQ.	DATE:	DOSE
						GIVEN BY
NEW MEDICATION ☐	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY					
BEFORE ADMISSION ☐	SS	DRUG			STOPPED DATE:	DATE
	DOSE	ROUTE	INDICATION		INITIALS:	TIME
NEW DOSE ☐	PRESCRIBER (PRINT & SIGN)			MAX.FREQ.	DATE:	DOSE
						GIVEN BY
NEW MEDICATION ☐	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY					
BEFORE ADMISSION ☐	TT	DRUG			STOPPED DATE:	DATE
	DOSE	ROUTE	INDICATION		INITIALS:	TIME
NEW DOSE ☐	PRESCRIBER (PRINT & SIGN)			MAX.FREQ.	DATE:	DOSE
						GIVEN BY
NEW MEDICATION ☐	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY					
BEFORE ADMISSION ☐	VV	DRUG			STOPPED DATE:	DATE
	DOSE	ROUTE	INDICATION		INITIALS:	TIME
NEW DOSE ☐	PRESCRIBER (PRINT & SIGN)			MAX.FREQ.	DATE:	DOSE
						GIVEN BY
NEW MEDICATION ☐	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY					

Patient's Own Medicine
For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.
For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.
For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.
For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

Name

CHI No

2504826311
CASSIDY
Neil
2/2 14 Ingleby Drive
Glasgow, Lanarkshire
25/04/198
G31 2P

Drug Allergies / Sensitivities **None Known** ☑ **Yes** ☐ **(provide details below)**

Nurse/Midwife Administration by Syn matic Relief Policy or other Protocol
- Authorised Nurses/Midwives Only (Maximum number of doses as per protocol)

Warning: Check the As Required and Regular Prescription sections to ensure that the drug has not already been prescribed by a doctor.

DATE	DRUG	DOSE	ROUTE	TIME (24hr)	NURSE (PRINT & SIGN)	GIVEN BY	TIME GIVEN (24hr)

Notes for Users

I PRESCRIBERS:

1. Prescribe drugs generically using the Approved Name (except in circumstances where bioavailability differences between brands of the same drug are so important as to warrant prescribing by brand name e.g. in the case of sustained release lithium or theophylline).

2. All prescription entries must be legible and made so as to be indelible (black ink is recommended).

3. Print & Sign your full name clearly against each prescription entry.

4. Time should be recorded in 24hr format e.g. 0600, 1800.

5. When drugs are discontinued, draw a diagonal line through the prescription box, initial and date the appropriate boxes and record reason.

6. If an existing prescription entry is to be modified, delete the existing prescription and re-write the new instructions as a new prescription entry

7. The following metric unit abbreviations must be used –

Milligram = mg — Gram = g
Millilitre = ml — Millimoles = mmol
Microgram / Nanogram / Units – **Do not abbreviate, write in full**

Fractions of a milligram should be written in micrograms. The use of decimal points should be avoided, if possible. If decimal points must be used a zero must be written in front of the decimal point (e.g. 0.5ml **NOT** .5ml).

8. The route of administration can be abbreviated using the following -

O	= oral	ID	= intradermal
IM	= intramuscular	SL	= sublingual
SC	= subcutaneous	PR	= per rectum
NG	= nasogastric	PEG	= percutaneous endoscopic gastrostomy
PV	= per vagina	RIG	= radiologically inserted gastrostomy
NJ	= nasojejunostomy	PEJ	= percutaneous endoscopic jejunostomy
TOP	= topical	ETT	= endotracheal
NEB	= nebulised	INHAL	= inhaled
IV	= intravenous		

Please note - intrathecal **must be written in full.**

FOR NURSES

1. The 'Once only', 'Regular' and 'As required' sections should be checked at each administration round to ensure that inadvertent omission or double dosing are avoided.

2. Insert initials in the relevant date column and time row each time a drug is administered.

3. Check that all drugs prescribed at a certain time have been administered.

4. If a drug is not administered enter the reason code in the appropriate date column and time row and also document the full reason in the patient's notes.

Codes for Non-Administration of Drugs

(3) Patient refused	(7) Patient asleep	(11) Unable to swallow	(14) Other - Record in nursing notes
(4) Drug not available	(8) Time varied on doctor's instructions	(12) No intravenous access	(15) Prescription clarification required
(5) Nil by mouth/fasting	(9) Dose withheld on doctor's instructions	(13) Patient Self-Administration of Medicine	
(6) Patient unavailable	(10) Nausea/vomiting		

Cat. No. 40995 Ver 4, 03/2010 GGC0029

[redacted]

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CASSIDY
Neil
2/2 14 Ingleby Drive
Glasgow, Lanarkshire
G31 2PT
M
25/04/1982
sticker

NHS
Greater Glasgow and Clyde

Emergency Care Nursing Documentation

Initial Investigations

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

Signature:

Communication

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

Signature:

Risk Assessments and Screening Tools

SEPSIS		Y	N	GMAWS	Y N
FAST		Y	N	Adult Support and Protection	Y N
Time:	Swallow Testing	Y	N	Mental Health Triage Assessment	Y N
Falls Risk (clinical judgement)		Y	N	Child Protection Concerns	Y N
4AT Assessment		Y	N	Frailty Assessment	Y N
				Public Protection (NOC)	Y N

Signature:

Pause for Discharge or Transfer

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

Signature:

Pat [redacted]
2504826311 M
CASSIDY
Neil 25/04/1982
Pati 2/2 14 Ingleby Drive
Glasgow, Lanarkshire G31 2PT
cker

NHS
Greater Glasgow and Clyde

Care Rounds Checklist

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

Signed [redacted] Name [redacted] Designation SN

Signed [redacted] Name [redacted] Designation HCA

Signed [redacted] Name [redacted] Designation [redacted]

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

			Times	21 54	88										
	1	**THINK DELIRIUM** Is the patient more confused/drowsy than normal? If yes inform registered nurse.		N	N										
	2	**PAIN: ASSESS AND ADDRESS** Is the patient distressed or in pain? If yes inform registered nurse.		N	N										
S	3	**SKIN INSPECTION** Pressure areas checked? R = RED D = Discloured PU - Pressure Ulcer INT = Intact M = Moisture		N	N										
K	4	**KEEP MOVING** Has the patient moved or walked?		W	BY										
		Bed R =Right side (30°) tilt L =Left side (30°) tilt B =Back Chair W/ST = Assist to walk / stand													
		ELIMINATION Does the patient need the toilet?		N	N										
I	5	I = Independent A - Assistance given IC = Incontinent (urine/ faeces)		I	I										
	6	**FOOD FLUIDS AND NUTRITION** Is the patient nil by mouth?		N	N										
		Drink taken?		N	N										
		Food, snack, or supplements taken?		N	N										
		Has oral hygiene been carried out as per care plan?		N	N										
	7	**ENVIRONMENT CHECK** Is the patient's call buzzer to hand? Is the area clutter free clean and safe? Does the patient have everything they require in safe reach? Is the bed in the lowest position?		Y	Y										
	8	**INFORMATION** Is there anything else I can help you with? Inform the patient of the time of return		N	N/A										
	9	**ESCALATION** Is there anything else I can help you with? Inform the patient of the time of return		N	N										
		Care provider		[redacted]	[redacted]										
		Role		SN	SN										

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

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25/04/198
ticker

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

NHS
Greater Glasgow and Clyde

PUDRA

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

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

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

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

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

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

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

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

Patient name .....

Patient CHI .....

or use sticker

NHS
Greater Glasgow and Clyde

Ongoing Care

	4 Hours	5 Hours	6 Hours	7 Hours	8 Hours	9 Hours	10 Hours	11 Hours	12 Hours
Time									
Nursing notes updated including (NEWS, MEWS,PEWS)									
vide details)									
IVI/IVABs									
Routine Medications prescribed and administered									
Falls risk assessment									
Skin assessed and supported (PURDRA)									
Analgesia assessment									
Nurse call system in place									
SBAR commenced									
Patient/ relatives dated									
mination needs met (does the patient know where toilet is)									
If patient not in cubicle space think about patients dignity requirements eg hearing aids, mobility aids, glasses, interpreter									
STOPPS completed									

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Glasgow, Lanarkshire
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Pat

ticker

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Nursing notes

Date and Time		Name/Signature
21:50 4/12/25	Pt brought into cub presented with unwell for 3/7 days has been disorientated and dizzy right pupil bigger. Hypertensive dizziness ... medical	[signature]
22:24 4/12/25	Pt seen by doctors. Pt had bloods taken ECG done awaiting plan	[signature]
23:00	Patient away at CT head at present.	[signature]
06:30	Pt became very agitated, wants to leave. Moved in to cubicle, lights turned off. Pt declined analgesia.	[signature] (SN)
08:15	Analgesia. Pt. appears settled.	[signature] SN
12:00	Bed ready in ward: continues to leave department for ...	[signature]

Patient name .....

Patient CHI .....

or use sticker

NHS
Greater Glasgow and Clyde

Nursing notes cont.

Date and Time	Name/Signature

My Admission Record

NHS Greater Glasgow and Clyde

2504826311
CASSIDY M
Neil 25/04/1982
2/2 14 Ingleby Drive
Glasgow, Lanarkshire
G31 2PT

Affix patient ID label

Hospital: GRI Ward: 70/71
Date of Admission: Time: (1pm)
Information obtained from: Name:
Patient ☑ Relative ☐ Other ☐ _____
Preferred Name:
Age: Telephone Number: 07495467956.
Consultant:

Communication

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

Preferred first contact	**Preferred second contact**
Name: Kelly Anne. Relationship: Sister Address: Telephone: 07594678457 Is this person aware of your admission? Yes ☑ No ☐ Can we share information with this person? Yes ☑ No ☐	Name: Relationship: Address: Telephone: Is this person aware of your admission? Yes ☐ No ☐ Can we share information with this person? Yes ☐ No ☐

Presenting Complaint / Diagnosis

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

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

No known allergies ☑

Relevant past medical history

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

Name: _____

Addr: 2504826311
CASSIDY
Neil M
DoB: 25/04/1982
CHI: 2/2 14 Ingleby Drive
Glasgow, Lanarkshire
Affi: G31 2PT

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

Yes ☐ No ☐

OR

Does someone have Guardianship?

Yes ☐ No ☐

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

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

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

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

POA/ Guardian

Name: _____ Relationship: _____ Contact Tel Number _____

Name: _____ Relationship: _____ Contact Tel Number _____

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

Carbapenemase-producing enterobacteriaceae (CPE)

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

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

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

MRSA Screening

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

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

Nasal ☐ Perineum ☐ Other ☐ Specify _____ Patient refused ☐

Creutzfeldt-Jakob Disease (CJD)

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

If **YES inform the IPCT** ☐

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Lifestyle

Smoking

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

Never smoked ☐ 10 cpd

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): J Keen Signature: J

Designation: CNS Date: 5/7/24

My Assessment Record

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1. Breathing and Circulation

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

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

2. Communication

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

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3. Senses

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

Can you describe where and what the pain is like?

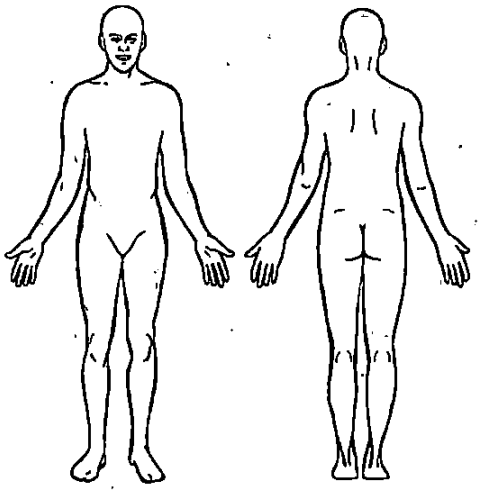
Have you had treatment / intervention for the pain?

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

Can you describe any chronic pain that you have?

What makes the pain better?

Mark current pain on body chart



Name: ___
Address: _
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DoB: ___
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4. Cognitive Status — THINK DELIRIUM

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

N.B. Think Delirium

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

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

and follow the guidance

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

5. Hydration and Nutrition

Do you have any food allergies or food intolerances?

What do you like to eat and drink?

What do you not like to eat and drink?

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

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

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Assessment of the patient's hydration and nutrition needs

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

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

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

6. Elimination

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

Assessment of the patient's elimination needs

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

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

What products do you normally use for this continence issue?

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

Date urinary catheter last changed ___/___/___

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

Bowels

When did your bowels last move?

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

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

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

What products do you normally use for this continence issue?

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

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

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

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

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

Pressure ulcer identified on admission: Yes ☐ No ☐

Pressure Ulcer Grade: _____

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

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

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

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8. Mobility

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

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

9 Maintaining a Safe Environment

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

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

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

10 Sleep and Rest

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

Name: _____

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11. Social Circumstances

Do you: Has a son aged 11 y-o (with Auntie as per ED

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? Kelly Anne - sister	✓	

If no support available contact Duty Social Worker

Duty Social Worker Required ☐ Not required ☐ Referred ☐

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

12. Emotional and Spiritual Care

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

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

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

Healthcare Chaplain informed Yes ☐ N/A ☐

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Required Support

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

Yes ☐ No ☐

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

Has the carer been advised of the Carers Information Line?

Yes ☐ No ☐ Not appropriate at this time ☐

Carers Information Line: 0141 353 6504

Carers Information Leaflet provided?

Yes ☐ No ☐

Are you:

Employed ☐ Unemployed ☐

Self-employed ☐ Retired ☐

Full time education ☐

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

Yes ☐ No ☐ Not applicable ☐

Do you have any money worries?

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

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

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

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

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

If yes when was patient referred ___/___/___

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Risk Assessments/Other Documentation

Additional NHSGGC Documentation	Required		Required documents completed		Date, Print and Sign when completed
	Yes ✓	No ✓	Yes ✓	No ✓	
Glasgow Assessment and Management of Alcohol (GAMA)				✓	3/12/25 - [illegible]
Generic Pain Scale Assessment Chart				✓	
[illegible]y Pain Scale (if unable to self report pain)				✓	
4AT and TIME for Detection, Management and Prevention of Delirium				✓	
Getting to Know Me – Relatives to complete				✓	
What Matters to Me				✓	
Screening Tool for Oropharyngeal Swallow Symptoms (STOPSS)				✓	
Malnutrition Universal Screening Tool (MUST)	✓		✓		
Adult Urethral Urinary Catheter (UCC) Insertion and Maintenance Care Plan				✓	
Bristol Stool Chart				✓	
Pressure Ulcer Daily Risk Assessment (PUDRA)	✓		✓		
Adult Wound Assessment and Management Chart				✓	
Moving and Handling Assessment			✓		
Risk Assessment	✓		✓		
Bedrail Risk Assessment			✓		

Clinical Notes

Date and Time	Notes	Print Name, Signature and Designation
	3/12/25 - Nursing	
	15:50 pt	
	41 yo male admitted c dizziness, altered sensation	
	to left hand side.	
	Had CTB ✓ showed likely space occupying	
	lesion. Neuro MAT	
	- Pt very anxious /worried. Managed to talk down	
	+ reassured.	

NHSGGC Bedrail Risk Assessment

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

THIS DOCUMENT DOES NOT REPLACE THE NEED FOR CLINICAL JUDGEMENT

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NHS Greater Glasgow and Clyde

Patient Name

CHI Number:

Use guidance on the reverse of this document when completing this Risk Assessment		DATE	5/1/24.							
		TIME	1530							
		WARD	3013.							
		HOSPITAL	GRI							
	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:									
16	Bedrails checked by:									
17	Date		5/1/24							

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 applicatio 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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Date 6/2/25

NHS
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Medical Receiving Unit

Cardiac Monitor Chart

Time	Rhythm	Rate	Chest pain		GTN infusion		Other Anti-arrhythmic meds	B/P
			Yes	No	Yes	No		
10.00 AM								
11.00 AM								
12.00 PM								
1.00 PM								
2.00 PM								
3.00 PM								
4.00 PM								
5.00 PM								
6.00 PM								
7.00 PM								
8.00 PM								
9.00 PM								
10.00 PM	ST	102		✓		✓	Commenced	
11.00 PM	ST	100		✓		✓		
12.00 AM	ST	107		✓		✓		
1.00 AM	ST	101		✓		✓		
2.00 AM	ST	103		✓		✓		
3.00 AM	SR	80		✓		✓		
4.00 AM	SR	83		✓		✓		
5.00 AM	SR	81		✓		✓		
6.00 AM	SR	89		✓		✓		
7.00 AM	SR	86		✓		✓		
8.00 AM								
9.00 AM								
10.00 AM								

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Care Plan

NHS
Greater Glasgow and Clyde

Date Commenced and Signature	7. Personal Hygiene, oral care, skin care and wound care	Date Discontinued and Signature	Date Commenced and Signature	9. Maintaining a safe environment, Technical Care	Date Discontinued and Signature
7/12 [signature]	Indep		-	Can Use of buzzer.	
				10. Sleep and Rest	
				Promote restful area	
	8. Mobility				
	May need supervision on feet			**12. Privacy, dignity and sexuality**	
				Negotiated care - Please record any planned involvement of patient/family in delivery of care	

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Liver Function Tests View Cumulative Results

Collected	29-Nov-2021 10:33	Received	29-Nov-2021 14:24
Reported	29-Nov-2021 16:42	Order Number	B,21.5319968.C
Status	Final	Source System	Telepath
Comments	REQUESTOR**collpase ?cause		

Test	Result	Ref. Range (Units)	Abnormality
Total Bilirubin	8	<20 umol/L (umol/L)	
ALT	* **64**	<50 U/L (U/L)	**Abnormal - high**
AST	32	<40 U/L (U/L)	
Alkaline Phosphatase	* **142**	30 - 130 U/L (U/L)	**Abnormal - high**
Albumin	43	35 - 50 g/L (g/L)	

* Abnormal ** Critically Abnormal

Glucose View Cumulative Results

Collected	29-Nov-2021 10:33	Received	29-Nov-2021 14:25
Reported	29-Nov-2021 15:37	Order Number	B,21.5319965.H
Status	Final	Source System	Telepath
Comments	Fasting sample REQUESTOR**collpase ?cause		

Test	Result	Ref. Range (Units)	Abnormality
Glucose	5.9	3.5 - 6.0 mmol/L (mmol/L)	

* Abnormal ** Critically Abnormal

C-reactive Protein View Cumulative Results

Collected	29-Nov-2021 10:33	Received	29-Nov-2021 14:24
Reported	29-Nov-2021 16:42	Order Number	B,21.5319968.C
Status	Final	Source System	Telepath
Comments	REQUESTOR**collpase ?cause		

Test	Result	Ref. Range (Units)	Abnormality
C Reactive Protein	4	0 - 10 mg/L (mg/L)	

* Abnormal ** Critically Abnormal

Bone Profile View Cumulative Results

Collected	29-Nov-2021 10:33	Received	29-Nov-2021 14:24
Reported	29-Nov-2021 16:42	Order Number	B,21.5319968.C
Status	Final	Source System	Telepath
Comments	REQUESTOR**collpase ?cause		

Test	Result	Ref. Range (Units)	Abnormality
Calcium	2.50	2.20 - 2.60 mmol/L (mmol/L)	
Calcium (adjusted)	2.44	2.20 - 2.60 mmol/L (mmol/L)	
Phosphate	0.87	0.80 - 1.50 mmol/L (mmol/L)	
Albumin	43	35 - 50 g/L (g/L)	
Alkaline Phosphatase	* 142	30 - 130 U/L (U/L)	**Abnormal - high**

* Abnormal ** Critically Abnormal

Urea & Electrolytes View Cumulative Results

Collected	16-May-2017 11:28	Received	16-May-2017 13:44
Reported	16-May-2017 16:13	Order Number	B,17.4629119.F
Status	Final	Source System	Telepath
Comments	Please note change to Abbott Enzymatic Creat method from 24/04/17 REQUESTOR**ABDOMINAL PAIN		

Test	Result	Ref. Range (Units)	Abnormality
Sodium	136	133 - 146 mmol/L (mmol/L)	
Potassium	4.3	3.5 - 5.3 mmol/L (mmol/L)	
Chloride	104	95 - 108 mmol/L (mmol/L)	
Urea	4.3	2.5 - 7.8 mmol/L (mmol/L)	
Creatinine	75	40 - 130 umol/L (umol/L)	
Estimated GFR	>60	>60 ml/min (ml/min)	

* Abnormal ** Critically Abnormal

Thyroid funct test View Cumulative Results

Collected	16-May-2017 11:28	Received	16-May-2017 13:44
Reported	16-May-2017 16:13	Order Number	B,17.4629119.F
Status	Final	Source System	Telepath
Comments	REQUESTOR**ABDOMINAL PAIN		

Test	Result	Ref. Range (Units)	Abnormality
TSH	0.61	0.35 - 5.00 mU/L (mU/L)	
Free T4	12.9	9.0 - 21.0 pmol/L (pmol/L)	
Total T3			

* Abnormal ** Critically Abnormal

Liver Function Tests View Cumulative Results

Collected	16-May-2017 11:28	Received	16-May-2017 13:44
Reported	16-May-2017 16:13	Order Number	B,17.4629119.F
Status	Final	Source System	Telepath
Comments	REQUESTOR**ABDOMINAL PAIN		

Test	Result	Ref. Range (Units)	Abnormality
Total Bilirubin	5	<20 umol/L (umol/L)	
ALT	12	<50 U/L (U/L)	
AST	16	<40 U/L (U/L)	
Alkaline Phosphatase	100	30 - 130 U/L (U/L)	
Albumin	39	35 - 50 g/L (g/L)	

* Abnormal ** Critically Abnormal

Glucose View Cumulative Results

Collected	16-May-2017 11:28	Received	16-May-2017 13:44
Reported	16-May-2017 15:03	Order Number	B,17.4629118.P
Status	Final	Source System	Telepath
Comments	Non-fasting sample REQUESTOR**ABDOMINAL PAIN		

Test	Result	Ref. Range (Units)	Abnormality
Glucose	*** 6.3**	3.5 - 6.0 mmol/L (mmol/L)	**Abnormal - high**

* Abnormal ** Critically Abnormal

GGT View Cumulative Results

Collected	16-May-2017 11:28	Received	16-May-2017 13:44
Reported	16-May-2017 16:13	Order Number	B,17.4629119.F
Status	Final	Source System	Telepath
Comments	REQUESTOR**ABDOMINAL PAIN		

Test	Result	Ref. Range (Units)	Abnormality
Gamma-GT	19	<70 U/L (U/L)	

* Abnormal ** Critically Abnormal

C-reactive Protein View Cumulative Results

Collected	16-May-2017 11:28	Received	16-May-2017 13:44
Reported	16-May-2017 16:13	Order Number	B,17.4629119.F
Status	Final	Source System	Telepath
Comments	REQUESTOR**ABDOMINAL PAIN		

Test	Result	Ref. Range (Units)	Abnormality
C Reactive Protein	4	0 - 10 mg/L (mg/L)	

* Abnormal ** Critically Abnormal

Urea & Electrolytes View Cumulative Results

Collected	06-Aug-2014 09:30	Received	06-Aug-2014 10:36
Reported	06-Aug-2014 12:09	Order Number	B,14.4737286.V
Status	Final	Source System	Telepath

Test	Result	Ref. Range (Units)	Abnormality
Sodium	140	133 - 146 mmol/L (mmol/L)	
Potassium	4.2	3.5 - 5.3 mmol/L (mmol/L)	
Chloride	105	95 - 108 mmol/L (mmol/L)	
Urea	3.7	2.5 - 7.8 mmol/L (mmol/L)	
Creatinine	66	40 - 130 umol/L (umol/L)	
Estimated GFR	>60	>60 ml/min (ml/min)	

* Abnormal ** Critically Abnormal

Thyroid funct test View Cumulative Results

Collected	06-Aug-2014 09:30	Received	06-Aug-2014 10:36
Reported	06-Aug-2014 12:09	Order Number	B,14.4737286.V
Status	Final	Source System	Telepath

Test	Result	Ref. Range (Units)	Abnormality
TSH	1.48	0.35 - 5.00 mU/L (mU/L)	
Free T4	13.5	9.0 - 21.0 pmol/L (pmol/L)	
Total T3			

* Abnormal ** Critically Abnormal

Liver Function Tests View Cumulative Results

Collected	06-Aug-2014 09:30	Received	06-Aug-2014 10:36
Reported	06-Aug-2014 12:09	Order Number	B,14.4737286.V
Status	Final	Source System	Telepath

Test	Result	Ref. Range (Units)	Abnormality
Total Bilirubin	4	<20 umol/L (umol/L)	
ALT	18	<50 U/L (U/L)	
AST	19	<40 U/L (U/L)	
Alkaline Phosphatase	88	30 - 130 U/L (U/L)	
Albumin	38	35 - 50 g/L (g/L)	

* Abnormal ** Critically Abnormal

Glucose View Cumulative Results

Collected	06-Aug-2014 09:30	Received	06-Aug-2014 10:36
Reported	06-Aug-2014 11:49	Order Number	B,14.4737287.R
Status	Final	Source System	Telepath

Test	Result	Ref. Range (Units)	Abnormality
Glucose	***6.1**	3.5 - 6.0 mmol/L (mmol/L)	**Abnormal - high**

* Abnormal ** Critically Abnormal

U&E View Cumulative Results

Collected	14-Apr-2008 23:30	Received	14-Apr-2008 23:49
Reported	15-Apr-2008 00:15	Order Number	N,08.3522553.V
Status	Final	Source System	Telepath

Test	Result	Ref. Range (Units)	Abnormality
Sodium	135	135 - 145 mmol/L (mmol/L)	
Potassium	[a] NA		
Chloride	108	95 - 108 mmol/L (mmol/L)	
Urea	* **2.1**	2.5 - 7.5 mmol/L (mmol/L)	**Abnormal - low**
Creatinine	[b] NA		
Estimated GFR	0	(ml/min)	

* Abnormal ** Critically Abnormal

[a] H

[b] H

LFTs View Cumulative Results

Collected	14-Apr-2008 23:30	Received	14-Apr-2008 23:49
Reported	15-Apr-2008 00:15	Order Number	N,08.3522553.V
Status	Final	Source System	Telepath

Test	Result	Ref. Range (Units)	Abnormality
Bilirubin	3	3 - 22 umol/L (umol/L)	
AST	[a] NA		
ALT	18	<50 U/L (U/L)	
Gamma-GT	[b] NA		
Alkaline Phosphatase	97	40 - 150 U/L (U/L)	
Total Protein	[c] NA		
Albumin	44	32 - 45 g/L (g/L)	
Globulins			

* Abnormal ** Critically Abnormal

[a] H

[b] H

[c] H

Glucose View Cumulative Results

Collected	14-Apr-2008 23:30	Received	14-Apr-2008 23:49
Reported	15-Apr-2008 00:15	Order Number	N,08.3522553.V
Status	Final	Source System	Telepath

Test	Result	Ref. Range (Units)	Abnormality
Glucose	*** 6.3**	3.5 - 5.5 mmol/L (mmol/L)	**Abnormal - high**

* Abnormal ** Critically Abnormal

CRP View Cumulative Results

Collected	14-Apr-2008 23:30	Received	14-Apr-2008 23:49
Reported	15-Apr-2008 00:15	Order Number	N,08.3522553.V
Status	Final	Source System	Telepath

Test	Result	Ref. Range (Units)	Abnormality
CRP	2.9	<10.0 mg/L (mg/L)	

* Abnormal ** Critically Abnormal

Bone Profile View Cumulative Results

Collected	14-Apr-2008 23:30	Received	14-Apr-2008 23:49
Reported	15-Apr-2008 00:15	Order Number	N,08.3522553.V
Status	Final	Source System	Telepath

Test	Result	Ref. Range (Units)	Abnormality
Alkaline Phosphatase	97	40 - 150 U/L (U/L)	
Total Protein	[a] NA		
Albumin	44	32 - 45 g/L (g/L)	
Globulins			
Calcium	2.16	(mmol/L)	
Calcium (adjusted)	2.14	2.10 - 2.60 mmol/L (mmol/L)	
Phosphate	[b] NA		

* Abnormal ** Critically Abnormal

[a] H

[b] H

Serum Folate View Cumulative Results

Collected	07-Feb-2025 08:12	Received	07-Feb-2025 11:28
Reported	07-Feb-2025 13:37	Order Number	B,25.4375489.Z
Status	Final	Source System	Telepath
Comments	REQUESTOR**.		

Test	Result	Ref. Range (Units)	Abnormality
Serum Folate	4.0	3.1 - 20.0 ug/l (ug/l)	

* Abnormal ** Critically Abnormal

Serum Ferritin View Cumulative Results

Collected	07-Feb-2025 08:12	Received	07-Feb-2025 11:28
Reported	07-Feb-2025 13:37	Order Number	B,25.4375489.Z
Status	Final	Source System	Telepath
Comments	Males 15-300 (<15 iron deficiency) Females 15-200 (<15 iron deficiency) 15-50 intermediate result. Consider iron deficiency in anaemic patients, older patients and those with inflammatory disease. REQUESTOR**.		

Test	Result	Ref. Range (Units)	Abnormality
Serum Ferritin	96	15 - 300 ug/l (ug/l)	

* Abnormal ** Critically Abnormal

Full Blood Count View Cumulative Results

Collected	07-Feb-2025 08:12	Received	07-Feb-2025 11:19
Reported	07-Feb-2025 11:27	Order Number	B,25.5874082.H
Status	Final	Source System	Telepath
Comments	REQUESTOR**.		

Test	Result	Ref. Range (Units)	Abnormality
White Blood Count	*** 12.9**	4.0 - 10.0 x10^9/l (x10^9/l)	**Abnormal - high**
Red Cell Count	5.01	4.50 - 6.50 x10^12/l (x10^12/l)	
Haemoglobin	154	130 - 180 g/l (g/l)	
Haematocrit	0.452	0.400 - 0.540 l/l (l/l)	
Mean Cell Volume	90.2	83.0 - 101.0 fl (fl)	
MCH	30.7	27.0 - 32.0 pg (pg)	
Platelet Count	320	150 - 410 x10^9/l (x10^9/l)	
Neutrophils	*** 8.2**	2.0 - 7.0 x10^9/l (x10^9/l)	**Abnormal - high**
Lymphocytes	3.3	1.1 - 5.0 x10^9/l (x10^9/l)	
Monocytes	*** 1.3**	0.2 - 1.0 x10^9/l (x10^9/l)	**Abnormal - high**
Eosinophils	0.09	0.02 - 0.50 x10^9/l (x10^9/l)	
Basophils	0.1	0.0 - 0.1 x10^9/l (x10^9/l)	
Nucleated RBC	0	(x10^9/l)	

* Abnormal ** Critically Abnormal

Active B12 View Cumulative Results

Collected	07-Feb-2025 08:12	Received	07-Feb-2025 11:28
Reported	07-Feb-2025 13:37	Order Number	B,25.4375489.Z
Status	Final	Source System	Telepath

Comments

Result in indeterminate range (25 - 70 pmol/L).
Consider treatment for B12 deficiency in following patient groups:
- Patients with a condition which may deteriorate quickly and have a severe effect on QoL (neurological, haematological cond'ns)
- Patients who are pregnant or breast feeding.
- Patients with a recognised cause of B12 deficiency (surgery or autoimmune gastritis).
Otherwise consider other causes of symptoms and if necessary repeat active B12 level at 3-6 months.
Note change in the B12 assay to an active B12 assay from 14/5/24.
REQUESTOR**.

Test	Result	Ref. Range (Units)	Abnormality
Active B12	66	>25 pmol/L (pmol/L)	

* Abnormal ** Critically Abnormal

Full Blood Count View Cumulative Results

Collected	04-Feb-2025 22:01	Received	04-Feb-2025 22:16
Reported	04-Feb-2025 22:22	Order Number	B,25.5869214.R
Status	Final	Source System	Telepath
Comments	REQUESTOR**unwell		

Test	Result	Ref. Range (Units)	Abnormality
White Blood Count	* **14.9**	4.0 - 10.0 x10^9/l (x10^9/l)	**Abnormal - high**
Red Cell Count	4.99	4.50 - 6.50 x10^12/l (x10^12/l)	
Haemoglobin	153	130 - 180 g/l (g/l)	
Haematocrit	0.446	0.400 - 0.540 l/l (l/l)	
Mean Cell Volume	89.4	83.0 - 101.0 fl (fl)	
MCH	30.7	27.0 - 32.0 pg (pg)	
Platelet Count	320	150 - 410 x10^9/l (x10^9/l)	
Neutrophils	* **10.0**	2.0 - 7.0 x10^9/l (x10^9/l)	**Abnormal - high**
Lymphocytes	3.7	1.1 - 5.0 x10^9/l (x10^9/l)	
Monocytes	1.0	0.2 - 1.0 x10^9/l (x10^9/l)	
Eosinophils	0.04	0.02 - 0.50 x10^9/l (x10^9/l)	
Basophils	0.1	0.0 - 0.1 x10^9/l (x10^9/l)	
Nucleated RBC	0	(x10^9/l)	

* Abnormal ** Critically Abnormal

Coagulation Screen View Cumulative Results

Collected	04-Feb-2025 22:01	Received	04-Feb-2025 22:16
Reported	04-Feb-2025 23:02	Order Number	B,25.5869213.V
Status	Final	Source System	Telepath
Comments	REQUESTOR**unwell		

Test	Result	Ref. Range (Units)	Abnormality
Prothrombin Time	11	9 - 13 s (s)	
PT Ratio	1.0		
APTT	32	27 - 36 s (s)	
APTT Ratio	1.0	0.9 - 1.1	
Thrombin time	12	11 - 15 s (s)	
TCT ratio	1.0		

* Abnormal ** Critically Abnormal

Full Blood Count View Cumulative Results

Collected	29-Nov-2021 10:33	Received	29-Nov-2021 16:32
Reported	29-Nov-2021 17:32	Order Number	B,21.6369711.E
Status	Final	Source System	Telepath
Comments	REQUESTOR**collpase ?cause		

Test	Result	Ref. Range (Units)	Abnormality
White Blood Count	* **10.6**	4.0 - 10.0 x10^9/l (x10^9/l)	**Abnormal - high**
Red Cell Count	4.85	4.50 - 6.50 x10^12/l (x10^12/l)	
Haemoglobin	150	130 - 180 g/l (g/l)	
Haematocrit	0.452	0.400 - 0.540 l/l (l/l)	
Mean Cell Volume	93.2	83.0 - 101.0 fl (fl)	
MCH	30.9	27.0 - 32.0 pg (pg)	
Platelet Count	329	150 - 410 x10^9/l (x10^9/l)	
Neutrophils	6.7	2.0 - 7.0 x10^9/l (x10^9/l)	
Lymphocytes	2.8	1.1 - 5.0 x10^9/l (x10^9/l)	
Monocytes	0.9	0.2 - 1.0 x10^9/l (x10^9/l)	
Eosinophils	0.07	0.02 - 0.50 x10^9/l (x10^9/l)	
Basophils	0.1	0.0 - 0.1 x10^9/l (x10^9/l)	
Nucleated RBC	0	(x10^9/l)	

* Abnormal ** Critically Abnormal

ESR View Cumulative Results

Collected	29-Nov-2021 10:33	Received	29-Nov-2021 16:32
Reported	29-Nov-2021 17:32	Order Number	B,21.6369711.E
Status	Final	Source System	Telepath
Comments	REQUESTOR**collpase ?cause		

Test	Result	Ref. Range (Units)	Abnormality
ESR	6	0 - 10 mm/hr (mm/hr)	

* Abnormal ** Critically Abnormal

Full Blood Count View Cumulative Results

Collected	16-May-2017 11:28	Received	16-May-2017 13:49
Reported	16-May-2017 14:48	Order Number	B,17.6061742.Q
Status	Final	Source System	Telepath
Comments	REQUESTOR**ABDOMINAL PAIN		

Test	Result	Ref. Range (Units)	Abnormality
White Blood Count	10.3	4.0 - 11.0 x10^9/l (x10^9/l)	
Red Cell Count	4.52	4.50 - 6.50 x10^12/l (x10^12/l)	
Haemoglobin	137	130 - 180 g/l (g/l)	
Haematocrit	0.413	0.400 - 0.540 l/l (l/l)	
Mean Cell Volume	91.4	80.0 - 100.0 fl (fl)	
MCH	30.3	27.0 - 32.0 pg (pg)	
Platelet Count	289	150 - 400 x10^9/l (x10^9/l)	
Neutrophils	7.2	2.0 - 7.5 x10^9/l (x10^9/l)	
Lymphocytes	2.0	1.5 - 4.0 x10^9/l (x10^9/l)	
Monocytes	*** 1.0**	0.2 - 0.8 x10^9/l (x10^9/l)	**Abnormal - high**
Eosinophils	0.06	0.00 - 0.40 x10^9/l (x10^9/l)	
Basophils	0	0.0 - 0.1 x10^9/l (x10^9/l)	
Nucleated RBC	0	(x10^9/l)	

* Abnormal ** Critically Abnormal

ESR View Cumulative Results

Collected	16-May-2017 11:28	Received	16-May-2017 13:49
Reported	16-May-2017 14:48	Order Number	B,17.6061742.Q
Status	Final	Source System	Telepath
Comments	REQUESTOR**ABDOMINAL PAIN		

Test	Result	Ref. Range (Units)	Abnormality
ESR	5	1 - 10 mm/hr (mm/hr)	

* Abnormal ** Critically Abnormal

Serum Vitamin B12 View Cumulative Results

Collected	06-Aug-2014 09:30	Received	06-Aug-2014 10:50
Reported	06-Aug-2014 13:49	Order Number	B,14.6407038.C
Status	Final	Source System	Telepath

Test	Result	Ref. Range (Units)	Abnormality
Serum Vitamin B12	460	200 - 900 ng/l (ng/l)	

* Abnormal ** Critically Abnormal

Serum Folate View Cumulative Results

Collected	06-Aug-2014 09:30	Received	06-Aug-2014 10:50
Reported	06-Aug-2014 13:49	Order Number	B,14.6407038.C
Status	Final	Source System	Telepath

Test	Result	Ref. Range (Units)	Abnormality
Serum Folate	*** 1.5**	3.1 - 20.0 ug/l (ug/l)	**Abnormal - low**

* Abnormal ** Critically Abnormal

Serum Ferritin View Cumulative Results

Collected	06-Aug-2014 09:30	Received	06-Aug-2014 10:50
Reported	06-Aug-2014 13:49	Order Number	B,14.6407038.C
Status	Final	Source System	Telepath

Test	Result	Ref. Range (Units)	Abnormality
Serum Ferritin	71	10 - 275 ug/l (ug/l)	

* Abnormal ** Critically Abnormal

Full Blood Count View Cumulative Results

Collected	06-Aug-2014 09:30	Received	06-Aug-2014 10:50
Reported	06-Aug-2014 13:49	Order Number	B,14.6407038.C
Status	Final	Source System	Telepath

Test	Result	Ref. Range (Units)	Abnormality
White Blood Count	10.5	4.0 - 11.0 x10^9/l (x10^9/l)	
Red Cell Count	* **4.15**	4.50 - 6.50 x10^12/l (x10^12/l)	**Abnormal - low**
Haemoglobin	136	130 - 180 g/l (g/l)	
Haematocrit	* **0.389**	0.400 - 0.540 l/l (l/l)	**Abnormal - low**
Mean Cell Volume	93.7	80.0 - 100.0 fl (fl)	
MCH	* **32.8**	27.0 - 32.0 pg (pg)	**Abnormal - high**
Platelet Count	251	150 - 400 x10^9/l (x10^9/l)	
Neutrophils	6.2	2.0 - 7.5 x10^9/l (x10^9/l)	
Lymphocytes	3.2	1.5 - 4.0 x10^9/l (x10^9/l)	
Monocytes	* **0.9**	0.2 - 0.8 x10^9/l (x10^9/l)	**Abnormal - high**
Eosinophils	0.2	0.0 - 0.4 x10^9/l (x10^9/l)	
Basophils	0.1	0.0 - 0.1 x10^9/l (x10^9/l)	
Nucleated RBC	0	(x10^9/l)	

* Abnormal ** Critically Abnormal

ESR View Cumulative Results

Collected	06-Aug-2014 09:30	Received	06-Aug-2014 10:50
Reported	06-Aug-2014 13:49	Order Number	B,14.6407038.C
Status	Final	Source System	Telepath

Test	Result	Ref. Range (Units)	Abnormality
ESR	9	1 - 10 mm/hr (mm/hr)	

* Abnormal ** Critically Abnormal

Full Blood Count View Cumulative Results

Collected	14-Apr-2008 00:00	Received	14-Apr-2008 23:46
Reported	15-Apr-2008 00:02	Order Number	R,08.5135520.H
Status	Final	Source System	Telepath
Comments	REQUESTOR**SKULL FRACTURE & MACHETTE WOUND		

Test	Result	Ref. Range (Units)	Abnormality
WBC	***15.8**	4.0 - 11.0 x10^9/l (x10^9/l)	**Abnormal - high**
RED CELL COUNT	4.90	4.50 - 6.50 x10^12/l (x10^12/l)	
HAEMOGLOBIN	15.6	13.0 - 18.0 g/dl (g/dl)	
HAEMATOCRIT	0.449	0.400 - 0.540 l/l (l/l)	
MCV	91.6	76.0 - 99.0 fl (fl)	
MCH	31.8	27.0 - 32.0 pg (pg)	
RDW	13.3	11.5 - 14.5 % (%)	
PLATELETS	295	150 - 400 x10^9/L (x10^9/L)	
NEUTROPHILS	***12.8**	2.0 - 7.5 x10^9/L (x10^9/L)	**Abnormal - high**
LYMPHOCYTES	2.0	1.5 - 4.0 x10^9/l (x10^9/l)	
MONOCYTES	***1.0**	0.2 - 0.8 x10^9/l (x10^9/l)	**Abnormal - high**
EOSINOPHILS	***0**	0.04 - 0.40 x10^9/l (x10^9/l)	**Abnormal - low**
BASOPHILS	0.02	0.01 - 0.10 x10^9/l (x10^9/l)	

* Abnormal ** Critically Abnormal

Coag Screen View Cumulative Results

Collected	14-Apr-2008 00:00	Received	14-Apr-2008 23:46
Reported	15-Apr-2008 00:02	Order Number	R,08.5135520.H
Status	Final	Source System	Telepath
Comments	This report does not include any comment on the platelet count. REQUESTOR**SKULL FRACTURE & MACHETTE WOUND		

Test	Result	Ref. Range (Units)	Abnormality
PT	* **13**	9 - 12 s (s)	**Abnormal - high**
PT C Ratio	1.1	0.9 - 1.1	
APTT	27	25 - 37 s (s)	
APTT Ratio	0.9	0.8 - 1.2	
TCT	11	11 - 15 s (s)	
TCT Ratio	0.8	0.8 - 1.2	

* Abnormal ** Critically Abnormal

Mid Stream Urine

Performed	30-Apr-2026 17:28	Received	01-May-2026 14:23
Reported	02-May-2026 09:02	Order Number	M,26.1124865.C
Status	Final	Source System	Telepath

Microbiology Final

```
Report issued by NHS GG&C Microbiology North Sector
                        Enquiries 0141 201 8551
** FINAL REPORT **

INVESTIGATION: Urine Culture
SPECIMEN TYPE: Mid Stream Urine

CONS/GP: Dr Caroline J. Dely  Order No:IS29553741
LOCATION: P1 Townhead HC Glasgow
------------------------------------------------------

RESULT:    No significant growth

Microbiology guidance/contact/eReferral details here:
https://rightdecisions.scot.nhs.uk/ggc-microbiology/

Tests included in UKAS Accreditation (8078) Scope.

------------------------------------------------------
Senders ref. no.

Authorised by: Automatic release by system
Date/Time authorised: 02.05.2026  09:00
** END OF REPORT **
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H.pylori serology View Cumulative Results

Collected	16-May-2017 11:28	Received	17-May-2017 16:52
Reported	19-May-2017 14:43	Order Number	V,17.0106689.S
Status	Final	Source System	Telepath
Comments	For advice regarding Helicobater pylori please contact your local microbiology department This is a SERUM sample. REQUESTOR**ABDOMINAL PAIN		

Test	Result	Ref. Range (Units)	Abnormality
H.pylori antibody	DETECTED		

* Abnormal ** Critically Abnormal

STROKE PATIENTS REFERRED FOR ORTHOPTIC AND VISUAL FIELD ASSESSMENT

Date of referral: 11th Feb 2025.

Patient Details:

NAME Neil Cassidy DOB 2504826311

ADDRESS 2/2 14 Ingleby Drive, Glasgow, G31 2PT

CONTACT TEL. 07731855475

GP L Zhang, Townhead Medical Practice, Townhead Health Centre, 16 Alexandra Parade, Glasgow,Glasgow,G31 2ES, 0141 483 1740

Referring Practitioner:

Name & Profession: Laura Gordon / Stroke OT TL

Contact Tel/Page 01412013796

Location of patient GRI HASU

Expected Date of Discharge 7th February 2025

Discharge to : Home X Rehab Unit ☐ Other ☐

Specify .....

Suspected defect

Visual field defect	X	☐
Neglect		☐
Diplopia	X	☐
Other visual symptoms		☐

Please specify .....

Comments

OT :

Independent with ADL at ward and functional transfers and mobility.
Vision:
On ax appears to have inferior left upper quadrant visual field impairment. Min impacting on function, Diplopia, temporary
Plaster eye patches given to help support in task, advised not to wear patch at all time.
No OT CST required.
Patient to be referred to orthoptist for ax as OP. Will be referred via referral management and copy of referral also sent to
orthoptist's at Stobhill
Patient discharge from OT at GRI HASU

Details of stroke:

Right medial occipital infarct

as shown on CT. Further areas of infarction are present in the right thalamus and hippocampus which

I can not clearly identify on CT from 4-2. No haemorrhage. No substantial background white matter disease. No other findings of note

Previous Patient Notes for Occupational Therapy (newest at the top).

Note: Specialty search returns patient notes from 13th November 2018 onwards. Patient notes older than that date, tagged Historical Notes, that don't have a specialty assigned can only be viewed within the Patient Notes section in the Clinical Documents tree.

Patient Note		**Inpatient Note**
Date/Time: 11-Feb-2025 11:33	**Created By:** Occupational Therapist - Laura Gordon	**Role:** AHP - GGC
Specialty: Occupational Therapy	**Organisation:**	Sensitive

Note:

OT acute stroke service GRI

O- orthoptic referral uploaded to portal and sent to referral management today and orthoptist at Stobhill for appointing.

P- patient was discharged from HASU on Friday 7th Feb 2025. No CST required or home care support

Patient Note		**Inpatient Note**
Date/Time: 07-Feb-2025 16:25	**Created By:** Occupational Therapist - Laura Gordon	**Role:** AHP - GGC
Specialty: Occupational Therapy	**Organisation:**	Sensitive

Note:

OT acute stroke HASU GRI

OT assessment completed and uploaded onto portal.

P_ patient to be referred via referral management to orthoptist for ax as out patient due to L VF and diplopia for stroke orthoptic ax - see assessment on portal for detail

Discharged OT at HASU

Previous Patient Notes for Physiotherapy (newest at the top).

Note: Specialty search returns patient notes from 13th November 2018 onwards. Patient notes older than that date, tagged Historical Notes, that don't have a specialty assigned can only be viewed within the Patient Notes section in the Clinical Documents tree.

Patient Note		**Inpatient Note**
Date/Time: 07-Feb-2025 12:11	**Created By:** Specialist Stroke Physiotherapist - Suzanne Brain	**Role:** AHP - GGC
Specialty: Physiotherapy	**Organisation:**	Sensitive

Note:

07/02/2025

S/ Pt complaining that his knee is clicking when walking. Has been going out of the ward and down the stairs for a cigarette therefore no concerns about managing his stairs at home. Feels his L hand is clumsy but has just been seen by Laura Gordon (OT) and has been provided with exercises.
O/ 5/5 MP bilat knees
Good static balance - able to maintain with feet close together and eyes closed
- unsteady with single leg stance R & L (pt reports this is normal for him)
Gait: reciprocal pattern, good step length and cadence very minimal hyperextension and intermittent L knee
Rx/ Provided with stroke of luck QR code for green pathway - to complete co-ordination exs, balance and hip/knee exs
A/ Very limited assessment as pt going for CT. No obvious weakness and mobilising indep on/off the ward. No need to assess on stairs as pt reports doing these when going off the ward.
P/ D/C from PT

Previous Patient Notes for Acute Specialties GGC (newest at the top).

Note: Specialty search returns patient notes from 13th November 2018 onwards. Patient notes older than that date, tagged Historical Notes, that don't have a specialty assigned can only be viewed within the Patient Notes section in the Clinical Documents tree.

Patient Note		**Remote Consultation**
Date/Time: 06-Feb-2025 16:21	**Created By:** smoking cessation advisor - Samina Ghani	**Role:** AHP - GGC
Specialty: Acute Specialties GGC	**Organisation:**	Sensitive

Note:

QYW Hospital Stop Smoking Service
Reviewed patient not ready to stop at present. Info given where to get stop smoking help in the community. No further input required from service unless he changes his mind. Please re-refer to service.

CHI: 2504826311

Glasgow Royal Infirmary

2

Total Att: 6

12 Mth Att: 0

Title: MR

CASSIDY **Neil**

DOB **25/04/1982** Age: **42y** Sex: **Male**

2/2 14 Ingleby Drive

Glasgow
Lanarkshire
G31 2PT
07731855475

Next of kin: **CRAWFORD, Kellyann**
Relationship: **Sister**

GP: **L Zhang**
0141 483 1740

Attendance Date: **04/02/2025** Arrival Time: **19:06**

Registration Time: **19:06** Date of Incident: **04/02/2025**

Major Incident Desc:

Reason for Attendance: **unwell**

Nursing Assessment

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

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

Presenting Complaint:

Observation Date: **04/02/2025 20:30** Nurse name: **Nurse Lindsay Dolan**

Temp	**36.5**	C
HR	**91**	bpm
BP	**142/105**	mmHg
MAP	**117.33**	mmHg
RR	**18**	bpm
SpO2	**98**	%
Oxygen		%

BM	**4.7**	mmol/L
PF		l/min
Expected PF		l/min
Weight		kg
Height		cm
Visual Acuity		
Left		
Right		
Corrected?		

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

Pupils-Right		Pupils-Left	
Size (mm)	**4**	Size (mm)	**3**
Reaction	**Y**	Reaction	**Y**

Nursing Notes: **"NEWS 1 GCS 15 FAST NEGATIVE - unwell for 3/7 days today has been disoriented and dizzy ? right pupil bigger HYPERTENSIVE IN TRIAGE " left bp 160/44 headache**

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

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

Date	**Clinical Notes**
	Seen By / Time Seen

Once Only Prescriptions (Including Tetanus Prophylaxis)

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

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Emergency Department

NHS
Greater Glasgow and Clyde

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25/04/1982

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

Clinical Notes

Date	Time	Name	Grade	Speciality
04/12/25	1223.	Brand	CoF	Em

(44) Smoker 20/day

3/7 visual disturbance.

Sudden onset after a cough.

"Like a blotch".

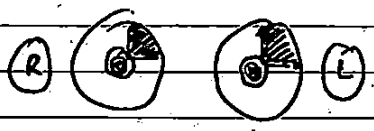
Normal VA throughout.

O/E: Pertel.

No pain.

Diplopia horizontally

No nystagmus.



Normal P/S/C all 4 limbs. CN intact otherwise.

Imp: ? PCCS.

Plan: CT brain.

D/W Dr S Boyce.

- Rule out Bleed
- If (N), (H) w/ option f/u.

CT prov. report.

- Space occupying lesion
- (R) occipital lobe
- No midline shift.

↳ Admit medics for MR.

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Clinical Notes

Date	Time	Name	Grade	Speciality
	0630	Pt agitated ++ - shouting with bang outside + lights		
		Headache on-going		
		Attempted to leave.		
		Talked down into cubicle + analgesia		
5/2/25				

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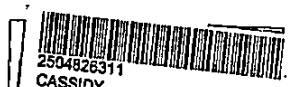
Emergency Department



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Clinical Notes

Date	Time	Name	Grade	Speciality

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

Diagnosis and Plan

Review/Discussed with:

Handover

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

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Glasgow Royal Infirmary
Acute Medicine Unit

(Part B - Medical Admission)

NHS
Greater Glasgow and Clyde

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Date & Time 21:00 5/9/25 Consultant

Ward Review (Should be completed within 2hrs of transfer from ED)

Check List

- VTE ☐
- Med - Rec ☐
- Kardex ☐
- CxR ☐
- ECG ☐
- Oxygen ☐
- Patient on Bleeders list ☐

IMT-2 Anne Milligan

42 ♂ ~~Admitted~~ PC: Rt & VL BLL sensory disturbance

Background:
Stage 1 COPD
H. Pylori 2017
Anxiety

Sister, Kelly, present

HPC: 5/52 history of intermittent sensory disturbance affecting L VL & LL & face. Each episode lasts <10 min then fully resolved.
2/7 overnight "felt like had a stroke"
Sudden onset of same, ± visual disturbance, small patch of visual loss LVQ.
Struggling to look at lights & phone due to brightness. "felt like I was drunk"
No headache.
Postural presyncope
No fits.
No weight loss.
° Cough / fever / SOB.
° Haemoptysis / haematuria / melaena
Otherwise well recently

Sthe lives ± 12yo autistic son (full custody)
Unemployed. T - total.
Doesn't drive
Rt handed.
Smokes 1/4 cigarettes / day.
Smokes cannabis - 2 joints / day.

Ward Review

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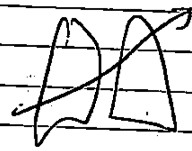
Usually (I) all ADLs

O/E A - maintaining
B - RR 18
SpO2 96% RA.
No ↑ resp effort



C - HR 104 ↔
BP 140/80
WWP, CRT < 2s
JVP ↔; no oedema
HS: I+II+0.
Calves SNT

urea 22
WCC 14.9
12 lead ECG - NSR

D - Temp 37
GCS 15/15
PEARL

E -
CN exam - (N) visual fields grossly. Small points missing from ~~R LUQ~~ LLQ field
↓ on checking eye movements, diplopia throughout, worse c any movement.
° nystagmus.
(N) facial sensation & power.
(N) uvula.

Neuro.

	LUL	RUL	LLL	RLL
Tone	↑	N	N	N
Power	5/5 →			
Reflexes	N →			
Co-ord	↓	N	↓	N
Sensation	↓	N	N	N

° Speech disturbance
Paraesthesia throughout L LUL
The heel-toe test. Romberg's -ve
Only light touch sensation tested

CTB - Provisional report - area of hypodensity R occipital lobe in keeping c SOL. Contrast imaging recommended.
Cons RIV of report - "likely reflect PCA territory infarct". Suggest MRI.

PTO

NHS GG&C Adult Risk Assessment for Venous Thromboembolism (VTE)

[excluding orthopaedics, obstetrics & ENT who have specialty-specific policies]

- **Risk Assessment must be completed for all patients within 24 hours of admission to hospital**
- **Patients must be reassessed every 48-72 hours or sooner if condition changes**
- **Reassessment must be documented in Kardex**
- **Please complete risk assessment and then sign and date Risk Assessment Result box at bottom of page.**

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Operative patients | **Non-operative patients**

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

Yes ☐ | No ☐

Does the patient have any risk factors for thrombosis? (tick √ all that apply)

Age >60	☐	Use of oestrogen-containing contraceptive therapy	☐
Active cancer or cancer treatment	☐	Use of hormone replacement therapy or tamoxifen	☐
Dehydration	☐	Pregnancy or < 6 weeks post partum	☐
Known thrombophilias	☐	Critical care admission eg HDU/ITU	☐
Obesity (BMI>30)	☐	Surgical procedure with total anaesthetic/surgical time >90 min, or >60 min if surgery on lower limb or pelvis	☐
Current significant medical condition e.g. Serious infection, Heart failure, Respiratory disease or Inflammatory disease	☐	Acute surgical admission with inflammatory or intra-abdominal condition including Pelvic Inflammatory Disease	☐
Personal history or first degree relative with a history of VTE	☐	Hip fracture	☐
Varicose veins with phlebitis	☐	All gynaecological surgery except uncomplicated gynaecological diagnostic day case procedures	☐

- No thromboprophylaxis required.
- Continue to reassess every 48-72 hours or sooner if condition changes.
- Document all reassessments in drug kardex.
- **Complete Risk Assessment Result Box.**

Yes, 1 or more risk factors identified ☐ | **No risk factors identified ☐**

Indicators of high risk bleeding (tick √ all that apply)

Active bleeding	☐	Lumbar puncture, epidural/spinal anaesthesia • Expected within the next 12 hours • Within the previous 4 hours	☐
Acquired bleeding disorders (e.g. liver failure)	☐	Other procedure with high bleeding risk – discuss with senior if unsure	☐
Concurrent use of other anticoagulants (e.g. warfarin, rivaroxaban, apixaban, edoxaban) is a contra-indication to additional phamacological thromboprophylaxis	☐		
Acute stroke (within 14 days)	☐	Acute bacterial endocarditis	☐
Persistent uncontrolled hypertension (BP > 230/120 mmHg)	☐	Surgery expected within the next 12 hours	☐
Thrombocytopenia (<75 x 10⁹/l)	☐	Trauma with high bleeding risk e.g. Head Injury	☐
Untreated inherited bleeding disorders (e.g. haemophilia or von Willebrands)	☐	eGFR <30ml/minute/1.73m²: Dose reduction required	☐
High risk of peri- or post-procedural bleeding, e.g. neurosurgery , spinal, posterior eye surgery and thyroid surgery	☐	Heparin induced Thrombocytopenia	☐

- **Discuss with senior clinical staff before deciding to prescribe pharmacological prophylaxis**
- Consider mechanical prophylaxis e.g. AES unless contra-indicated.
- Reassess patient every 48-72 hours or sooner if condition changes.

No contraindications to pharmacological prophylaxis identified ☐ | **Contraindications to pharmacological prophylaxis identified ☐**

Operative patients – Enoxaparin 40mg + AES ☐*
*prior to application of AES, please check contraindications to AES
Non-operative patients – Enoxaparin 40mg ☐
Prescribe Enoxaparin at 6pm
[on day of surgery, at the later of either 4h post-op or 6pm]
Reduce Enoxaparin to 20mg if <50Kg or eGFR <30ml/minute/1.73m² ☐
If weight> 120kg, consider Enoxaparin 40mg bd (see StaffNet Guideline).
Discontinue at discharge or when returned to pre-morbid mobility

Contraindications to anti-embolism stockings (AES) Y ☐ N ☐

Peripheral neuropathy	☐
Peripheral arterial disease	☐
Cellulitis or Gross oedema	☐
Leg deformity or Fragile skin	☐
Leg / foot ulcers	☐
Allergy	☐
Unusual leg size/shape	☐

Risk assessment result – please tick √ all that apply

VTE risk factors: YES ☐ NO ☐ Indicators of high risk bleeding: YES ☐ NO ☐ Prescribed: LMWH ☐ AES ☐ NONE ☐
Patient informed of VTE risks and benefits of thromboprophylaxis YES ☐ NO ☐ N/A ☐ Information leaflet provided YES ☐ NO ☐
Print Assessor's Name: _____ Signature: _____ Date: _____

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Medicine Reconciliation Form

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Source of information: ECS ☐

Patient ☐ Relative/carer ☐ GP surg ☐ GP computer printout/letter ☐ Patient's own drugs ☐ Other (specify)

Admission Medicines (including OTC, herbal, homeopathic)				Plan for medicines (unless i… medication should be con…				
Name	Dose	Freq	Route	Amend	withold	Stop	continue	Reason for alteration
No regular meds. - previously on nitrazepam								
Allergies/adverse events								

List obtained by _____ Designation _____

Recently altered/discontinued medicines prior to admission and reasons why _____

Compliance aid? Y☐ N☐ Type _____ If, Y Community Pharmacy _____ Phone _____

Senior Medical staff review: Sign _____ Title _____ Date and Time _____

Reviewed by pharmacist _____ Date and Time _____

Comments

Consultant Review

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(42) Not added

Abd Nx noted

Recent [illegible] the [illegible] & LUQ

Smoker, [illegible] cons [illegible]
Nil [illegible]

WCC 14 CT – Hypodensity (R) occipital lobe
CRP 4
?PCA infarct acute/old

⇒ Needs MRI to define whether infarct acute/old, then further work-up / Rx accordingly

?/ Arrange patient MRI

Check List	
VTE ☐	
Med - Rec ☐	
Kardex ☐	
CxR ☐	
ECG ☐	
Oxygen ☐	
EDD	

PRINT NAME [illegible]	DESIGNATION [illegible]
SIGNATURE [illegible]	DATE & TIME 6/2/[illegible] [illegible]

Clinical Notes

Imp — History more in keeping c̄ stroke but scan raising possibility of SOL also.

Plan 1) Aspirin 300mg STAT
2) CXR
3) MRI - brain - call tomorrow to expedite ? fast track as would dictate management plan.
4) Stroke R/V
5) STAT zopiclone
6) If SOL confirmed, CT CAP & d/w oncology / neurosurgeons.
7) Check TFTs, lipids, bone profile tomorrow
8) Declined NRT.

[signature]

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[redacted]

Full update given to Neil & Kelly (sister). Frustrated by wait time, arrived on ward at 1pm from ED & no R/V until now.
Neil understanding of possibility of stroke +/- brain tumour. I explained plan to treat empirically as stroke given history & scan findings & involve stroke team whilst awaiting MRI-B (which we will try to get on urgent basis tomorrow).
Neil asked about treatment options.
I explained all hypothetical for now as we don't know the definite diagnosis. If tumour confirmed, will require more ~~to~~ tests - 1ry vs 2ry tumour & most d/w oncology +/- neurosurgeons, but this is something we can discuss in more detail if ~~the~~ scan report consistent c̄ this.
Neil understandably upset. Asked to go for a walk - feels worried about his son & siblings if has devastating diagnosis. I reassured him we will investigate as quickly as we can.
V. grateful for update

[signature]

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Clinical Notes

6/2/25
3.50 NURSING

PATIENT INITIALY AGITATED BUT
FOLLOWING PABV r/v HAS SETTLED
TO SLEEP
OBSERVATIONS STABLE
TOLERATING ORAL DIET c FLUIDS

David
DAVID MSR
S/N

6/2/25 WR CONSULT
10 40

? SOL / PCA INFARCT WCC 14.9.
N 10.

OBS ✓ Hb 91
0 INFECTIVE SYMPTOMS
CHEST CLEAR
HS I + II + 0
MOOD 8NY

→ ANTIS-LOW
- MRI
BLOODS TODAY
CONTINUE AS FOR STROKE r/v

McCrae
CONSULTANT

6/2/25 Comment
1500
MRI – Ⓡ occipital int A
- int A Ⓡ thalamus/
hippocampus.
Nx. i – + review not Jx. Ⓛ arm/leg
tingling & blurring
Ⓛ superior quadrantanopia noted
prev. & not demonstrable
currently

Clinical Notes

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① am / leg ↓ coordinat'
Nupure

⇒ Plan 1/ PT / OT review
2/ ASA / statin
3/ Rpt bld mane
c lipids.
4/ CTA.
5/ OASW (agreeable
c PIS given) —
72: ECG
6/ Echo.
7/ Smoking cess =

[signature]

Nursing note (Day)

6/2/25 16:46pm — Pt received alert + orientated post handover. Clinical obs obtained + charted, news remains stable. All medication to be administered. Pt requested PRN antiemetics, administered with good effect. Pt attended MRI + CXR today. Bedside note initiated and updated. Pt remains indep with mobility + elimination. No issues to be escalated at present. [signature]

6/2/25 2235 Nursing Notes
Patient nbo in HASU - Alert & orientated, Tolerating DOF. Independently mobile around the room. NEWS - 1 (HR). Commenced on cardiac monitor - ST on graph. 4PIC in place and no concerns at present.
[signature]

7/2/25 0400 Patient reports being unable to sleep earlier and zopiclone 7.5mg was provided with good effect. Sleeping at present. Obs stable as in NEWS chart.
[signature]

[redacted]

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☐ NURSING ☐

Please tick ✔ appropriate directorate

2504826311 M
CASSIDY 25/04/1982
Neil
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Glasgow, Lanarkshire G31 2PT

Date & Time		Signature, Print Name & Designation
5/2/25	D/W pt. and two brothers	
0115 -	Obviously very upset about potential	BRENDA COF
	Cancer dlx.	
	I have explained that this is	
	not a diagnosis only an interpretation	
	of the scan	
	I said that there will be a formal	
	report and further testing/scans.	
	I have apologised for the news	
	and encouraged them to take	
	the Dx one step @ a time	
	Referred medics.	
	PRN analgesia + antiemetic.	
5/2/25	Patient handed over by	
09:30	night staff.	
	42 y/o c/o headache	
	and ? new @ R sided	
	superior quadrantopia.	
	CTB → new soft @ occipital	
	lobe. Possible new malignancy	
	Px for admission to medics	
	for MRI.	
	News = 2.	
	Patient very distressed that	

83949 GGC0072

Date & Time		Signature, Print Name & Designation
5/2/25	he is still in ED.	
09:45	Angry about the situation	
	and very frustrated.	
	Explained that we are	
	waiting for a medical	
	bed and apologised for	
	the wait.	
	Patient threatening to DAMA	
	if he does not get	
	a bed in the next few	
	hours.	
	plan: await admission	
	to medical bed.	
	Mg. Patt.	
	(CTF).	
	nursing notes.	
	pt agitated since arrival	
	on round 50, dealing around	
	with family, given 5mg	
	diazepam as per regime	
	→ no change in pts	Agitation
	4-5 members of family with	
	pt have advised to try keeps	
	2 to bedside to try reduce	
	noise around pt.	
	pts brother wanting to stay	
	overnight, advised not really	
	suitable to stay in the room	
	at the moment, welcome to	
	use relatives room to be near	
	as family named pt ward	settle

[redacted]

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☐ NURSING ☐

Please tick ✔ appropriate directorate

2504826311
CASSIDY M
Neil 25/04/1982
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Date & Time		Signature, Print Name & Designation
7/2/25 09:00	Stroke? / SJ / HASU [illegible]	
	42 o? [illegible] Smoker / COPD / Cannabis use	
	Admitted [illegible] [illegible]	
	[illegible]	
	[illegible] 2/7 ago [illegible] VF loss (sup. quadrantanopia)	
	CT B: Normal	
	MRI B: (R) occipital infarct. (R) thalamus + hippocampal [illegible] (? [illegible] PCA territory)	
	CTA: [illegible] (no [illegible])	
	Bloods: [illegible] CXR: Awaited	
	[illegible]	
	[illegible]: [illegible] ✓	
	BP 121/83. NEWS = 0.	
	[illegible] sup. quadrant [illegible] right but no [illegible] to confirm	
	[illegible]	
	NIHSS = 1.	

83949 GGC0072

Date & Time		Signature, Print Name & Designation
	Very [illegible] [illegible]	2 yrs
	ago. [illegible]	
	[illegible] CTA [illegible]	
	today [illegible]	
	[illegible]	
	[illegible]	
		[signature]
07/02/25 11[55]	Self caring with hygiene needs this am.	
	No complaints offered. Mobilising and	
	leaving ward at times for cigarette.	
	Had CT angio, result awaited. Awaiting	[signature] S/N
	ECHO. NEWS 0. Keen for home.	Kirsty McDougall
	Cardiac monitor discontinued as patient	
	taking off regularly to leave ward.	[signature] S/N
16[40]	Patient discharged home. Cannula	
	removed. Discharge letter and medication	
	given and explained. Own transport	
	arranged. Discharged from ward as	[signature] S/N
	per Dr Slevin.	Kirsty McDougall

[redacted]

2504826311
CASSIDY M
Neil 25/04/1982
2/2 14 Ingleby Drive
Glasgow, Lanarkshire
G31 2P

THIS STROKE BUNDLE MUST BE FOLLOWED FOR ALL STROKE/TIA PATIENTS

Admitted to GRI	☐	Date: 4/2/25	Time: 0230	Ward: AE
Admission to H/ASU	☐	Date: 6/2/25	Time: 2230	WITHIN DAY 1 OF ADMISSION
CT	☐	Date: 5/2/25	Time: 1009	WITHIN 24HOURS OF ADMISSION
Swallow Assessment	☑	Ward:	Name:	WITHIN 4 HOURS OF ADMISSION
		Date: 5/2/25	Time: 0010	
Aspirin 1st Administered	☐	Date: 6/2/25	Time: 2135	WITHIN 1 DAY OF ADMISSION
IPC	☒	Date:	Reason, if not given: mobile	

SWALLOW ASSESSMENT NOW WITHIN 4 HOURS OF ADMISSION

TO PASS THE BUNDLE ALL ELEMENTS MUST BE COMPLETED WITHIN TIME SCALES SET OUT.

Inpatient prescription & administration record for Neil Cassidy (2504826311)

Admission: 05/02/2025 => 07/02/2025

01:00
10/02/25

Patient Demographics

CASSIDY Neil (2504826311)
DOB: 25/04/1982
2/2 14 Ingleby Drive, Glasgow,
Lanarksh,
G31 2PT

Admitted: 05/02/2025 13:15
Discharged: 07/02/2025 17:21

Transfer history

Admission	2025-02-04 19:07:00	RAE GRI ED
Transfer	2025-02-05 13:15:00	R53 GRI WARD 53
Transfer	2025-02-05 14:28:00	R50 GRI WARD 50
Transfer	2025-02-05 14:28:01	R53 GRI WARD 53
Transfer	2025-02-05 14:28:02	R50 GRI WARD 50
Transfer	2025-02-06 21:53:00	R53 GRI WARD 53

Responsible Consultant history

Assigned No Consultant	04/02/25	19:07
Muhammad Adrees	05/02/25	13:15
Claire Rooney	05/02/25	17:33
Helen Slavin	07/02/25	07:08

Allergy

Admission Allergy Check performed by: Minjie Zhou
Current recorded allergy (reaction): No Known Drug Allergies

ASPIRIN 300 mg Dispersible Tablets

☒ 06/02/25 22:00 300 mg ONCE daily at 10pm (Oral) — Anne Milligan

06/02/25 22:00 — 06/02/2025 21:35 — David Rose

☒ 05/02/25 22:14 300 mg (Oral) — Anne Milligan

05/02/25 22:14 — 05/02/2025 22:37 — David Rose

ATORVASTATIN 80 mg Tablets

☒ 06/02/25 22:00 80 mg ONCE daily at 10pm (Oral) — Alan Cameron

06/02/25 22:00 — 06/02/2025 21:35 — David Rose

Diazepam 5 mg Tablets

☒ 05/02/25 15:45 5 mg (Oral) — Minjie Zhou

05/02/25 15:45 — 05/02/2025 15:48 — Lyndsay Wilson

Diazepam 2 mg Tablets

☒ 07/02/25 14:17 2 mg (Oral) — Dorothy Mundt-Leach

07/02/25 14:17 — 07/02/2025 14:21 — Kirsty McDougall

Zopiclone 3.75 mg Tablets

☒ 05/02/25 21:47 3.75 mg (Oral) — Anne Milligan

05/02/25 21:47 — 05/02/2025 22:37 — David Rose

Zopiclone 7.5 mg Tablets

☒ 07/02/25 00:29 7.5 mg (Oral) — Aishah Qureshi

07/02/25 00:29 — 07/02/2025 00:30 — Emma Connor

Cyclizine 50 mg in 1 mL Injection as required

☒ 06/02/25 10:06 50 mg every 8 HOURS (Intramuscular) FOR NAUSEA *prescribed as part of either/or protocol:Cyclizine 50Mg Po/Im/Iv Pm 8H* — Praisey Mathew

GRI5051 Nur2 — Alternative administered

☒ 06/02/25 10:06 50 mg every 8 HOURS (Intravenous Slow Bolus Injection) FOR NAUSEA *prescribed as part of either/or protocol:Cyclizine 50Mg Po/Im/Iv Pm 8H* — Praisey Mathew

GRI5051 Nur2 — Alternative administered

Cyclizine 50 mg Tablets as required

☒ 06/02/25 10:06 50 mg every 8 HOURS (Oral) FOR NAUSEA *prescribed as part of either/or protocol:Cyclizine 50Mg Po/Im/Iv Pm 8H* — Praisey Mathew

50.00 — 06/02/2025 15:49 — GRI5051 Nur2

Key: Prescription details | Recorded as "Admitted On" | Prescribed as "Self Administer" | Discontinuation details | HEPMA Prescription additional notes | HEPMA Patient admission notes (admission specific) | HEPMA Patient retained notes (not specific to admission)

Report developed by HEPMA teams NHS Lanarkshire, NHS Dumfries & Galloway, NHS Ayrshire & Arran and NHS Greater Glasgow & Clyde

HEPMA MAP v1.0

Key: Prescription details | Recorded as "Admitted On" | Prescribed as "Self Administer" | Discontinuation details | HEPMA Prescription additional notes | HEPMA Patient admission notes (admission specific) | HEPMA Patient retained notes (not specific to admission)

Report developed by HEPMA teams NHS Lanarkshire, NHS Dumfries & Galloway, NHS Ayrshire & Arran and NHS Greater Glasgow & Clyde

2504526311
CASSIDY
Neil
2/2 14 Ingleby Drive -
Glasgow, Lanarkshire
G31 2PT
M
25/04/1982

Care Plan

NHS
Greater Glasgow and Clyde

Care discussed with patient ☐ Yes ☐ No ☐ Unable			If unable, give reason:			
Care discussed with family ☐ Yes ☐ No ☐ Unable			If unable, give reason:			
Date commenced & signature	1. Breathing and circulation		Date discontinued & signature	Date commenced & signature	Getting to Know Me / What Matters to Me	Date discontinued & signature
7/1	- Undressed					
	Ul issues					
					5. Hydration and Nutrition	
					- Kof	
	2, 3. Communication and senses					
	Communicates well					
					6. Elimination	
	4. Cognitive status				R Indep	

Care Rounds Checklist

Date: 5/2/15

2504828311
CASSIDY
Neil
2/2 14 Ingleby Drive
Glasgow, Lanarkshire
M
25/04/1982
G31 2PT

NHS Greater Glasgow and Clyde

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

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

'N... ...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	14:00	21:00
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	N	0	N
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.	N	0	N
S	3	**SKIN INSPECTION** Pressure areas checked:	N	0	1
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)		0	INT
K	4	**KEEP MOVING** Has the patient moved or walked?	Y	0	Y
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B		0	1
		Chair Assist to walk or stand (W/ST)		0	
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	I	0	1
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?	N	0	N
		Drink taken?	Y	0	Y
		Food, snack, or supplement taken?	Y	0	Y
		Has oral hygiene been carried out as per care plan?		0	1
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?	Y	0	Y
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.	N	0	Y
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	N	0	NA
		Care provider / role			

Care Rounds Variance Sheet

Attach Addressograph Label
Ward:

NHS Greater Glasgow and Clyde

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

mi • 278936 v2.1 • GGC0098

Care Rounds Checklist

Date: 06/02/25

NHS Greater Glasgow and Clyde

Attached label:
2504826311
M CASSIDY
Neil — M — 25/04/1982
2/2 14 Ingleby Drive
Glasgow, Lanarkshire
G31 2P
Ward

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

1. Signed [signature] Name DAVID [illegible] Designation S/N
2. Signed ______ Name ______ Designation ______
3. Signed ______ Name ______ Designation ______

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

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

		Times	00	5 00	09 20	13 20	18 20	20 30	22 00											
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	S	N	N	N	N	N	N											
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.	S	N	N	N	N	N	N											
S	3	**SKIN INSPECTION** Pressure areas checked:	S	I	I	I	I	I	I											
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	S	INT	INT	INT	INT	INT	/											
K	4	**KEEP MOVING** Has the patient moved or walked?	S	Y	Y	Y	Y	Y	Y											
		Bed Right side (30° tilt) – **R** Left side (30° tilt) – **L** Back – **B**	S	I	B	-	B	I	I											
		Chair Assist to walk or stand (W/ST)	S		W	W/ST	W/ST		I											
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	S	I	I	I	I	I	I											
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?	S	N	N	N	N	N	N											
		Drink taken?	S	Y	Y	Y	Y	Y	[illegible]											
		Food, snack, or supplement taken?	S	Y	Y	Y	Y	N	Y											
		Has oral hygiene been carried out as per care plan?	S	I	I	I	I	I	I											
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?	S	Y	Y	Y	Y	Y	Y											
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.	S	Y	N	N	N	Y	N											
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	S	NK	NK	NK	NK	NK	[illegible]											
		Care provider / role	[signature]	[signature]	[signature]	[signature]	[signature]	[signature]	[signature]											

Care Rounds Variance Sheet

Attach Addressograph Label

Ward:

NHS Greater Glasgow and Clyde

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

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Care Rounds Checklist

Date: 07/02/25

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 EMACKENZIE. Name EMACKENZIE Designation SN
2. Signed [signature] Name Kirsty McDougall Designation SN
3. Signed _____ Name _____ Designation _____

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

Att
2504826311
M CASSIDY 25/04/19
2 Nell
2/2 14 Ingleby Drive
War Glasgow, Lanarkshire G31 2F
ST
Paste:

NHS Greater Glasgow and Clyde

'Must dos' for me. Ask the patient if there is anything they want specifically done today:
No thanks

		Times	08	06 00	08	12	16 10															
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	N	N	N	N	N															
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.	N	N	N	N	N															
S	3	**SKIN INSPECTION** Pressure areas checked:	NT	NT	N	N	N															
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	I	-	I	I	I															
K	4	**KEEP MOVING** Has the patient moved or walked?	W	S	S	S	S															
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	I	-	I	I	I															
		Chair Assist to walk or stand (W/ST)	I	-	I	I	I															
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	I	I	I	I	I															
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?	N	N	N	N	N															
		Drink taken?	I	S	S	S	S															
		Food, snack, or supplement taken?	-	S	S	S	S															
		Has oral hygiene been carried out as per care plan?	I	-	I	I	I															
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?	Y	Y	Y	Y	Y															
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.	NT	NT	N	N	N															
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	NA	NA	NA	NA	NA															
		Care provider / role	N	N	SN	SN	SN															

Care Rounds Variance Sheet

Attach Addressograph Label

Ward:

NHS Greater Glasgow and Clyde

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

mi • 278936 v2.1 • GGC0098

2504826311
CASSIDY [illegible] M
Neil 25/04/1982

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: 30 Date: 5/12/14 Time: 11:30	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).	✓				
2. Check walking aid (if required) is in reach and in use.	✓				
3. Check call bell is in reach and working. Provide and document alternative measures if patient is unable to use call bell.	✓				
4. Check footwear is safe (refer to NHSGGC Footwear guidance).	✓				
5. If glasses are worn, check they are available and in use.	✓ cd				
6. If hearing aid/s are worn, check they are working and in use.	n/a				

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	[signature]									

Highlight risk of fall at the ward safety brief.

Patient Details	

FALLS INTERVENTION CHECKLIST

NHS Greater Glasgow and Clyde

Complete for all patients identified at risk of falling.

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

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

EVIDENCE ALL INTERVENTIONS IN NURSING CARE PLAN

Feb 17 mi • 294647c Version 1_0 • GGC0233

[redacted]

Fluid Balance Chart

2504826311
CASSIDY
Neil
M
25/04/1982

Hospital: GRI
Ward: 30/T4 (CFM)
Date: 5/12/25

Reason for Fluid Balance Chart _____
Is patient fluid restricted? Yes ☐ No ☐
If yes how many mls in 24 hours? _____
Fluid balance from previous 24hrs +/- _____

Does patient require thickened fluids?
Yes ☐ No ☐ Stage _____
Is the patient on an oral supplement? Yes ☐ No ☐ If YES please indicate:
1. Type _____ circle how many daily 1 2 3
2. Type _____ circle how many daily 1 2 3
Signature: _____ Designation: _____

ONLY RECORD INTAKE CONSUMED NOT WHAT IS GIVEN TO PATIENT

Time	Input									Output							
	Oral Fluids		Enteral		IV / Other				Running Total INPUT	Urine	Gastric / Vomit	Bowel	Type	Type	Type	Running Total OUTPUT	Initials
	Type	Volume	Type	Volume	Type	Volume	Type	Volume									
00:00																	
01:00																	
02:00																	
03:00																	
04:00																	
05:00																	
06:00																	
07:00																	
08:00																	
09:00																	
10:00																	
11:00																	
12:00																	
13:00																	
14:00																	
15:00	commenced.																
16:00																	
17:00																	
18:00																	
19:00																	
20:00																	
21:00																	
22:00																	
23:00									DISCONTINUED								
								*Total Intake	[redacted]						*Total Output	[redacted]	

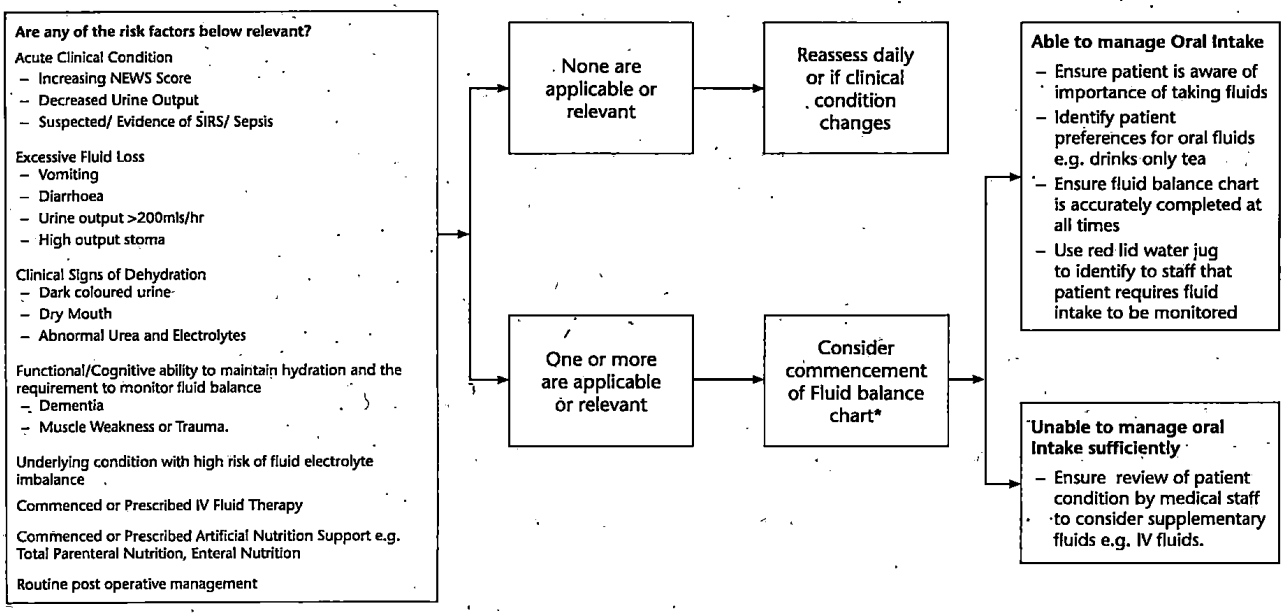
*Transfer Total Intake/Total Output/24hr Fluid Balance to Cumulative Fluid Balance on back of Food, Fluid and Nutrition Profile.

*24 hr Fluid Balance +/-

220665

Guide to commencing fluid balance charts

The risk factors below must be considered when deciding if a patient requires their fluid intake & output to be accurately monitored. Please where possible discuss with the patient the need for fluid balance to be monitored and involve them in decisions regarding fluid balance e.g. drinking preferences, encouragement of fluids.



Medical staff MUST review the patients fluid balance as part of their routine medical review if risk factors present give cause for concern.

*Palliative care patients may have the above risk factors present however it may not be necessary or appropriate to monitor fluid balance and this should be recorded in the patient's clinical notes

MIS • EDU • 237971-2

Fluid Balance Chart

2504826311

M CASSIDY 25/04/19[illegible]
12 Neil
2/2 14 Ingleby Drive
Glasgow, Lanarkshire G31 2F
*T

Hospital: GRI
Ward: 50
Date: 07/02/25

Reason for Fluid Balance Chart _____

Is patient fluid restricted? Yes ☐ No ☐

If yes how many mls in 24 hours? _____

Fluid balance from previous 24hrs
+/- _____

Does patient require thickened fluids?
Yes ☐ No ☐ Stage _____

Is the patient on an oral supplement? Yes ☐ No ☐ If YES please indicate:
1. Type _____ circle how many daily 1 2 3
2. Type _____ circle how many daily 1 2 3

Signature: _____ Designation: _____

ONLY RECORD INTAKE CONSUMED NOT WHAT IS GIVEN TO PATIENT

Time	Input									Output							
	Oral Fluids		Enteral		IV / Other				Running Total INPUT	Urine	Gastric / Vomit	Bowel	Type	Type	Type	Running Total OUTPUT	Initials
	Type	Volume	Type	Volume	Type	Volume	Type	Volume									
00:00																	
01:00																	
02:00																	
03:00																	
04:00																	
05:00																	
06:00																	
07:00																	
08:00	Breakfast	300							300	UTI							
09:00																	
10:00																	
11:00																	
12:00																	
13:00																	
14:00																	
15:00																	
16:00																	
17:00																	
18:00																	
19:00																	
20:00																	
21:00																	
22:00																	
23:00																	
								*Total Intake	[redacted]						*Total Output	[redacted]	

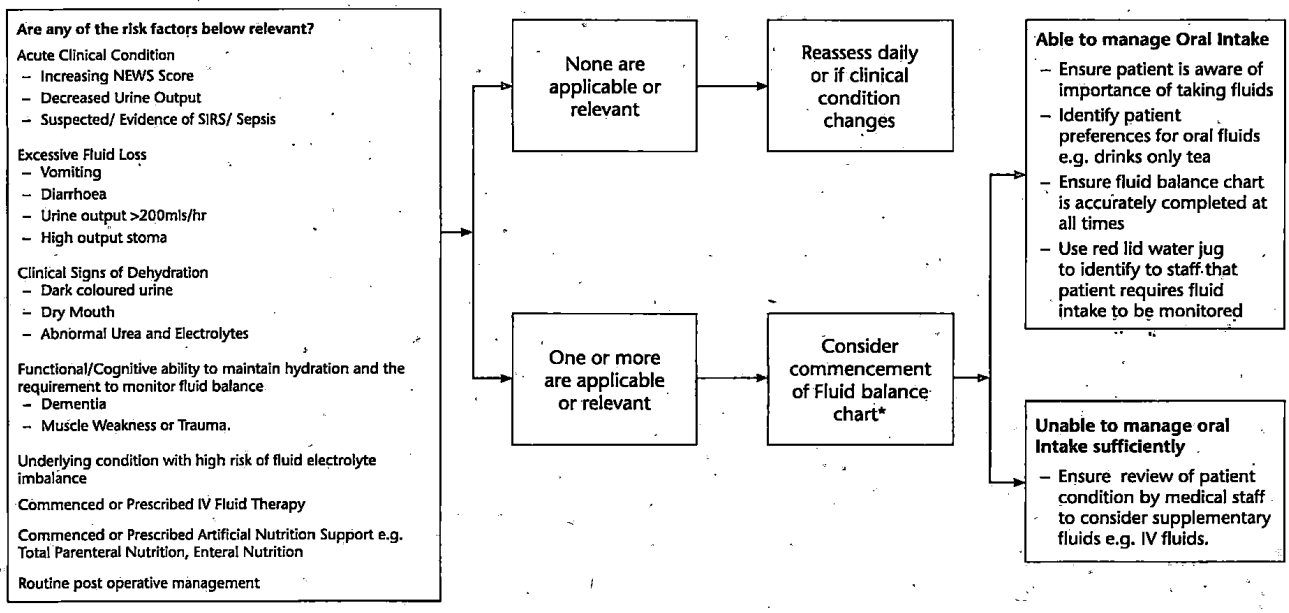
*Transfer Total Intake/Total Output/24hr Fluid Balance to Cumulative Fluid Balance on back of Food, Fluid and Nutrition Profile.

*24 hr Fluid Balance +/-

220665

Guide to commencing fluid balance charts

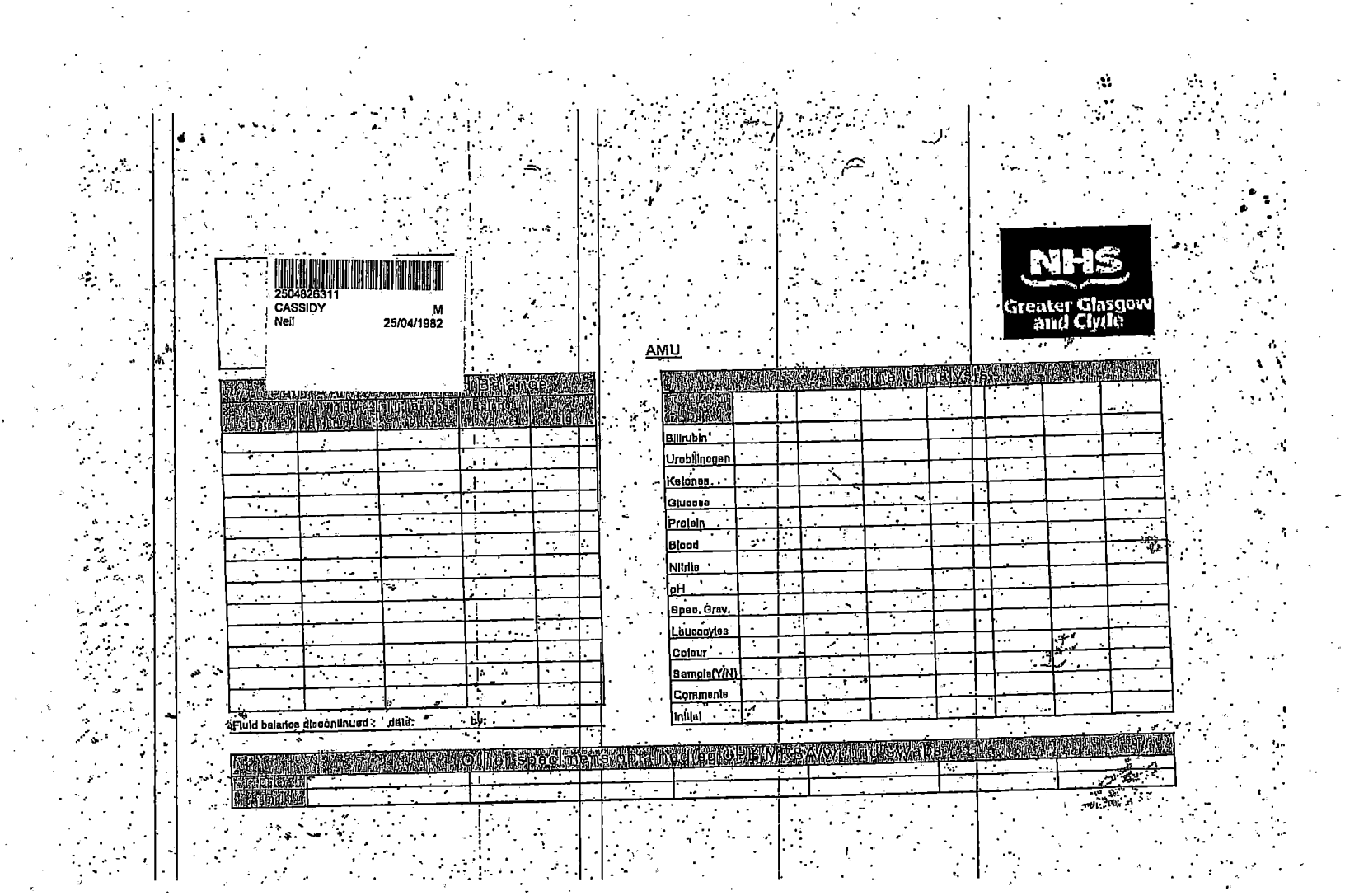
The risk factors below must be considered when deciding if a patient requires their fluid intake & output to be accurately monitored. Please where possible discuss with the patient the need for fluid balance to be monitored and involve them in decisions regarding fluid balance e.g. drinking preferences, encouragement of fluids.



Medical staff MUST review the patients fluid balance as part of their routine medical review if risk factors present give cause for concern.

*Palliative care patients may have the above risk factors present however it may not be necessary or appropriate to monitor fluid balance and this should be recorded in the patient's clinical notes

MIS • EDU • 237971-2



2504826311
CASSIDY M
Neil 25/04/1982

NHS Greater Glasgow and Clyde

AMU

Fluid balance

Fluid balance discontinued: date: by:

Routine Urinalysis

Bilirubin								
Urobilinogen								
Ketones								
Glucose								
Protein								
Blood								
Nitrite								
pH								
Spec. Grav.								
Leucocytes								
Colour								
Sample(Y/N)								
Comments								
Initial								

Urine Specimens Sent to Laboratory

Date/Time								
Initial								

2504826311
CASSIDY M
Neil 25/04/1982
2/2 14 Ingleby Drive
Glasgow, Lanarkshire
G31 2PT

MALNUTRITION UNIVERSAL SCREENING TOOL (MUST)

NHS Greater Glasgow and Clyde

Date 7/2/25 Time 13:30 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	5·5 cm	☐	☐	
Admission Weight	113 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	7/2/25							
Time	13:40							
Ward	30 (6m)							
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)	113							
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

JST STEP 5 Management Guidelines

MUST 1

- Check assistance required with eating and drinking (Red, Amber, Green).
- Check with patient /carer normal eating patterns and preferences.
- **Use a Food First Approach:**
  - Offering mid-morning, mid-afternoon and supper snack from ward supplies (e.g. bread with butter/jam, biscuits with butter/jam, cereal).
  - Offer full cream milk with and between meals.
  - Order additional MUST snack daily of patients choice (refer to 'catering' section in Nutrition Resource Manual).
- Encourage family and friends to bring in patient preferred snacks.
- Complete a food and drink recording chart, including all food and fluid consumed and refused, encouraging patient and family to complete where appropriate.
- Review and evaluate the above daily, clearly documenting issues actioned in nursing evaluation notes.

Is there documented evidence in the nursing evaluation notes that the above steps have been completed over a **72 hour period?**

YES → Is the patient's intake 'normal' or improved for them?

- YES →
  - Discontinue food and drink recording chart, documenting reason in nursing notes.
  - Continue with '**food first**' approach as above.
  - Rescreen at least every 7 days.
- NO →
  - Encourage higher calorie menu choices indicated with ✪
  - Continue with food and drink recording chart for 4 days, and if no improvement in intake, rescreen.

NO → Complete the above steps

MUST 2 OR GREATER

- Check assistance required with eating and drinking (Red, Amber, Green).
- Check with patient /carer normal eating patterns and preferences.
- **Use a Food First Approach:**
  - Offering mid-morning, mid-afternoon and supper snack from ward supplies (e.g. bread with butter/jam, biscuits with butter/jam, cereal).
  - Offer full cream milk with and between meals.
  - Order additional MUST snack daily of patients choice (refer to 'catering' section in nutritional resource manual).
- Encourage family and friends to bring in patient preferred snacks.
- Complete a food and drink recording chart, including all food and fluid consumed and refused, encouraging patient and family to complete where appropriate.
- Review and evaluate the above daily, clearly documenting issues actioned in nursing evaluation notes.

Is there documented evidence in the nursing evaluation notes that the above steps have been completed over a **72 hour period?**

YES → Is the patients intake 'normal' or improved for them?

- YES →
  - Discontinue food and fluid chart, documenting reason in nursing notes.
  - Continue with 'food first' approach as above.
  - Rescreen at least every 7 days.
- NO → Is the patient dying?
  - YES →
    - Discontinue food and drink recording chart.
    - Stop screening.
    - Offer food and fluid as appropriate.
  - NO →
    - Continue with food and drink recording chart.
    - Screen at least every 7 days.
    - Consider referral to **dietetics** via Trakcare.

NO → Complete the above steps

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/

mi • 285884 v3.0 • CGC0250

[redacted]

N	2504826311	
A	CASSIDY	
C	Neil	M
E	2/2 14 Ingleby Drive	25/04/1982
)	Glasgow, Lanarkshire	G31 2PT

Peripheral Venous Cannula (PVC) Insertion & maintenance

Please complete insertion details for each PVC inserted

Care & maintenance to be undertaken & documentation completed twice each day.

Modified Visual Infusion Phlebitis (VIP) Score		
PVC site appears healthy	0	No phlebitis: Continue care and maintenance
Either slight pain or redness near site	1	Possible first signs: Observe PVC site
Two or more: pain / redness / swelling	2	Early stage of phlebitis: **Remove and resite PVC**
All: pain / redness / hardening of surrounding area	3	Phlebitis/thrombophlebitis: **Remove and resite PVC** **Seek further advice**
As above and including: palpable venous cord	4	
As above and including: pyrexia	5	

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Insertion details: Date: 5/1/25 (Day 1) Time: ___:___	**Where inserted:** ☐ ED ☐ Theatre ☐ ITU/HDU ☐ Ward ___ ☐ Unknown	**Insertion site:** ☐ Hand ☐ Arm Other ___	**Side:** ☐ Left ☐ Right	**Size of cannula:** ☐ 26G Purple ☐ 24G Yellow ☐ 18G Green ☐ 23G Blue ☐ 16G Grey ☐ 20G Pink ☐ 14G Orange	**Inserted by:** Print: ___ Signature: ___ Designation: ___
Clinical indication:	☐ Diagnostics	☐ Resuscitation	☐ IV medications	☐ Fluids	☐ Transfusion
Insertion criteria:	Hand hygiene performed ☐ Yes ☐ No	Skin decontamination (2% chlorhexidine in 70% isopropyl alcohol) ☐ Yes ☐ No	Sterile transparent semi-permeable dressing affixed ☐ Yes ☐ No	PVC explained to patient/carer ☐ Yes ☐ No	

DRIFT PVCs are associated with an increased risk of phlebitis, thrombosis, infection and S.aureus bacteraemia.

Justify the need for your patient to have a PVC using the DRIFT mnemonic.
- ✓ **D**iagnostics - Does the patient need the PVC for a diagnostic procedure e.g. CT scan
- ✓ **R**esuscitation - Is the patient at risk of cardiac or respiratory arrest?
- ✓ **I**ntravenous (IV) - Does the patient require intravenous (IV) medication? Could these be switched to another route?
- ✓ **F**luids - Does the patient require IV fluids? Could this be switched or oral fluids?
- ✓ **T**ransfusion - Does the patient require a transfusion of blood products?

Signs of local or systemic infection

Local infection
- Erythema / inflammation
- Exudate
- Hot to touch
- Pain/tenderness

Systemic infection
- Hypotension
- Tachycardia
- Pyrexia

Adult IVOST Guideline:

Paediatric IVOST Guideline:

Always refer to full IV route to Oral route Switch Therapy (IVOST) guidelines

IV → Oral Antibiotic Switch Therapy (IVOST) Guideline

Review need for IV antibiotics daily

Can antibiotic therapy be stopped? (eg: alternative diagnosis)?

If ongoing antibiotics required - document patient progress/IVOST plan within 72 hours

Switch to oral when:

a **CLINICAL IMPROVEMENT** in signs of infection eg: temperature ≤37.9°C, reduction in the NEWS score, Improving SEPSIS

a **ORAL ROUTE** is available reliably (eating/drinking no concerns regarding absorption)

a **UNCOMPLICATED INFECTION** i.e. specialist advice not required prior to IVOST: Infection requiring specialist advice includes CNS infection, Cystic fibrosis, S. aureas bacteraemia (minimum 14 days IV), Endocarditis, Vascular graft or bone/joint infection, Undrainable deep abscess.

DO NOT use CRP in isolation to assess IVOST suitability as does not reflect severity of illness

Record the stop date on HEPMA

If IVOST criteria met → Switch to oral

Review MICROBIOLOGY results and NARROW THE SPECTRUM based on cultures

IF not responsive MICROBIOLOGY switch to oral as outlined below

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

PVCs should be removed as soon as no longer clinically indicated.

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Maintenance – to be completed twice daily (Observe for signs and symptoms of local or systemic infection)													
Date	Need for PVC reviewed today?		Any sign of PVC site infection?		Is the dressing intact?		Before / after PVC procedures; hand hygiene performed?		PVC patent?		What has been done?		Sign: Print: Designation:
	Day	Night	Day	Night	Day	Night	Day	Night	Day	Night	Day	Night	
Day 1 Insertion Date __/__/__	☐ Yes ☐ No	☐ Yes ☐ No	VIP ____	VIP ____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Left in situ ☐ Redressed ☐ Removed	☐ Left in situ ☐ Redressed ☐ Removed	Day Night
Day 2 6/8/25	☐ Yes ☐ No	☐ Yes ☐ No	VIP ____	VIP 0	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Left in situ ☐ Redressed ☐ Removed	☐ Left in situ ☐ Redressed ☐ Removed	Day Night
Day 3 07/08/25	☐ Yes ☐ No	☐ Yes ☐ No	VIP 0	VIP ____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Left in situ ☐ Redressed ☐ Removed	☐ Left in situ ☐ Redressed ☐ Removed	Day Night
Day 4	☐ Yes ☐ No	☐ Yes ☐ No	VIP ____	VIP ____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Left in situ ☐ Redressed ☐ Removed	☐ Left in situ ☐ Redressed ☐ Removed	Day Night
Day 5	☐ Yes ☐ No	☐ Yes ☐ No	VIP ____	VIP ____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Left in situ ☐ Redressed ☐ Removed	☐ Left in situ ☐ Redressed ☐ Removed	Day Night
Day 6	☐ Yes ☐ No	☐ Yes ☐ No	VIP ____	VIP ____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Left in situ ☐ Redressed ☐ Removed	☐ Left in situ ☐ Redressed ☐ Removed	Day Night
Day 7	☐ Yes ☐ No	☐ Yes ☐ No	VIP ____	VIP ____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Left in situ ☐ Redressed ☐ Removed	☐ Removed	Day Night

PVCs should be removed on day 7. Reassess ongoing needs and vessel health for most appropriate vascular access device. Date removed __/__/__					
Reason for removal	☐ Site infection	☐ Infiltration	☐ Extravasation	☐ End of treatment	Other:

[redacted]

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Glasgow, Lanarkshire
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(Inpatient) Moving and Handling Assessment Form

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

Body Build	
Weight	Height
Kg	cm
BMI	
Risk of Falls: Yes	No

Problems with comprehension, behaviour, co-operation (specify):

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

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

Hoist	Standaid	Walking Aid	Assistance	Supervision	Independent
Model		Aid Type	People: 1 2 ≥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			
	Independent bridging			

5. Move up / down bed

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

6. Lateral Transfer to / from trolley / bed

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

7. Sit up over side of bed

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

8. Into Bath or Shower

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

9. Walking

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

10. Other Instructions / Observations / Equipment Used

	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:	9/2/14		
Assessor's signature:			
Proposed Review date:			

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:	

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 Ateni)			

9. Walking

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

10. Other Instructions / Observations / Equipment Used

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

Pressure Ulcer Daily Risk Assessment (PUDRA)

NHS Greater Glasgow and Clyde

2504826311

CASSIDY M Neil 25/04/1982 2/2 14 Ingleby Drive Glasgow, Lanarkshire G31 2PT	Hospital: GRI Ward: 30 - CRM	**Points to consider:** • Use within 8 hrs of admission to care area • Re-assess daily and more frequently if a person's condition changes

Pressure damage	No RISK ↓	At RISK ↓	Grade 1 – non blanching skin Grade 2,3,4, suspected deep tissue injury (SDTI), ungradable pressure ulcer, Moisture Associate Skin Damage (MASD) ↓	Device Related Pressure Damage i.e. nasogastric, catheters, oxygen tubing ↓
YOU MUST CHECK SKIN at pressure points	Daily skin check	4 hourly positioning Complete SSKINS care plan (Overleaf)	2 hourly positioning with skin checks, Complete SSKINS care plan (overleaf)	All devices need a SSKINS care plan (overleaf)

1	PressureDamage	Does the person have Pressure damage; Grade 1, 2, 3, 4, SDTI, Ungradable?
2	Mobility	Does the person require assistance to mobilise or change position?
3	Continence	Does the person have moisture issues, or, continence issues with urine and/or faeces?
4	Nutrition	Does the person appear malnourished and/or unable to eat or drink?
5	Skin	Is skin compromised by any other source, e.g. medical devices; neurological deficit; surgery; medication; co-morbidities?
6	Judgement	In your clinical judgement, is this person at risk of developing pressure damage?

Date	Location of pressure damage	Grade of ulcer	Date	Location of pressure damage	Grade of ulcer
/ /			/ /		
/ /			/ /		
/ /			/ /		

If NO to all questions, continue Care Rounds Prescribed as assessed for individual need and re-assess daily.
If you have answered YES to any of the questions above, please complete the SSKINS care plan overleaf.

Date	Time	Pressure Damage	Mobility	Continence	Nutrition	Skin Compromised	Clinical Judgement	Check Skin	Signature
5/12/25	11:30	N	N	N	N	N	N	12 hrly	
6/12/25	09:00	N	N	N	N	N	N	12 hrly	
7 2 25	05:20	N	N	N	N	N	N	4 hrly	
/ /	:							hrly	
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Patient Centred SSKINS care plan

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

NB. Avoid patients lying on back/sitting for prolonged episodes, a total change of position is required, standing only is not sufficient

Attach Addressograph

NHS Greater Glasgow and Clyde

	S SKIN INSPECTION	S SURFACE	K KEEP MOVING	I INCREASED MOISTURE AND CONTINENCE MANAGEMENT	N NUTRITION	S SELF MANAGEMENT / SHARED CARE	Sign / Comments
Date of plan: 7/1/17	Check: • Pressure areas ____ hourly. • Skin under medical devices ____ hourly. • Specify medical devices used: Catheter ☐ Naso gastric ☐ Oxygen mask ☐ Nasal oxygen ☐ Vascular Access Device ☐ Off loading boot ☐ Other:	Specify: • Mattress: Foam • Cushion: • Detail additional pressure redistributing equipment: Off loading boot: ☐ Protective product:	• Reposition 3 hourly in bed. • Reposition ____ hourly in chair. • Overnight patient / carer has agreed to repositioning ____ hourly • Specify any manual handling equipment used: Tilting device ☐ • Knee bend in place ☐ Record reason for no knee bend:	• Does patient have Moisture Associated Skin Damage Yes ☐ • Skin care to be carried out ____hourly. • Specify products required for increased moisture / continence management: Barrier Cream ☐ Pad / Pants ☐	• Optimise nutrition and hydration. • Refer to MUST	• Provide information in a format appropriate to patient / family/ carer needs : • Specify: Leaflet ☐ Verbal ☐ Not provided record reason:	Date discontinued:
Date Reviewed:	Check: • Pressure areas ____ hourly. • Skin under medical devices ____ hourly. • Specify medical devices used: Catheter ☐ Naso gastric ☐ Oxygen mask ☐ Nasal oxygen ☐ Vascular Access Device ☐ Off loading boot ☐ Other:	Specify: • Mattress: • Cushion: • Detail additional pressure redistributing equipment: Off loading boot: ☐ Protective product:	• Reposition ____ hourly in bed. • Reposition ____ hourly in chair. • Overnight patient / carer has agreed to repositioning ____ hourly • Specify any manual handling equipment used: Tilting device ☐ • Knee bend in place ☐ Record reason for no knee bend:	• Does patient have Moisture Associated Skin Damage Yes ☐ • Skin care to be carried out ____hourly. • Specify products required for increased moisture / continence management: Barrier Cream ☐ Pad / Pants ☐	• Optimise nutrition and hydration. • Refer to MUST	• Provide information in a format appropriate to patient / family/ carer needs : • Specify: Leaflet ☐ Verbal ☐ Not provided record reason:	Date discontinued:

Screening Tool for Oropharyngeal Swallow Symptoms (STOPSS)

NHS Greater Glasgow and Clyde

N 2504826311
A 1 CASSIDY M
2 Neil 25/04/1982
D 2/2 14 Ingleby Drive
Glasgow, Lanarkshire
CR G31 2P

(Do not repeat STOPSS if inpatient Speech and Language Therapy management is ongoing)

Part 1: Is the patient fit for screening? (Patients with a tracheostomy follow the STOPSS for tracheostomy form.)

Can the patient:

- Maintain an upright sitting position in a bed or chair **AND**
- Stay awake and alert for 15 minutes while seated upright

N.B. Consider waiting 24-48 hrs post extubation if intubated for >24hrs

No ✓

Keep Nil By Mouth and alert medical staff.

- Implement and maintain full oral hygiene.
- Document plan for patient's medication route, hydration and nutritional status.
- **Recommence STOPSS** (new form) when oral intake is being reconsidered.

Sign: _____ Print: _____ Grade: _____
Date: _____ Time: _____

Yes – Proceed to Part 2 ✓

Part 2: If the patient meets any of the criteria below DO NOT water swallow test ✓

Weak or absent voice post extubation	
Recurrent unexplained chest infections or documented aspiration on formal investigation	
Poorly controlled respiration plus **new** swallowing difficulties	
Patient is reporting previously unsuspected swallowing difficulties	
Patient has a known swallowing problem (e.g. on a texture modified diet) and is experiencing **new** difficulties	

NB: Exclude aspiration resulting from vomiting, seizures, oesophageal stricture

No – Proceed to Part 3 ✓

Yes – Alert medical staff. Refer to Speech and Language Therapy through trakcare. (Part 3 **NOT** required)

Sign: _____ Print: _____ Grade: _____
Date: _____ Time: _____

Part 3: Water Swallow Test (Patients already on modified fluids should be tested with their usual fluid recommendation)

PART A:
Can the patient take 3 x 5ml teaspoons of water **WITHOUT** coughing **OR** choking **OR** becoming breathless **OR** hoarse **OR** gurgly?

No

1st Attempt – FAIL – Keep nil by mouth and **alert medical staff.** Repeat Part A within 3-12 hours. ✓
Sign Print: _____ Grade: _____
Date: _____ Time: _____

2nd Attempt – FAIL – Keep nil by mouth and **alert medical staff.** Refer to Speech and Language Therapy. ✓
Sign _____ Print: _____ Grade: _____
Date: _____ Time: _____

Yes ✓

PART B:
Can the patient drink 50 ml of water from a glass at a comfortable pace **WITHOUT** coughing **OR** choking **OR** becoming breathless **OR** hoarse **OR** gurgly?

No

1st Attempt – FAIL – Keep nil by mouth and **alert medical staff.** Repeat Part B within 3-12 hours. ✓
Sign _____ Print: _____ Grade: _____
Date: _____ Time: _____

2nd Attempt – FAIL – Keep nil by mouth and **alert medical staff.** Refer to Speech and Language Therapy. ✓
Sign _____ Print: _____ Grade: _____
Date: _____ Time: _____

Yes - PASS ✓

Commence normal fluids and Level 7- Easy to Chew or pre-admission modified diet+fluids. (local protocol applies for initial intake post head and neck cancer surgery and in Spinal units)

- Supervise the first mealtime and note any problems.
- If no problems observed proceed to previous oral intake
- If problems develop e.g. cough, gurgly voice, moist chest or chest infection consider nil by mouth, alert medical staff and refer to Speech and Language Therapy

Sign: J. Mustarde Print: J. Mustarde Grade: BS Date: 25/02/25 Time: 0010

NHSGGC NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

2504829311
CASSIDY
Neil
2/2 14 Ingleby Drive
Glasgow, Lanarkshire
M
25/04/1982
G31 2PT

	Date	Ward	Time
Admitted			
Transferred			
Transferred			
Transferred			
Transferred			

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

Document all actions and interventions

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

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

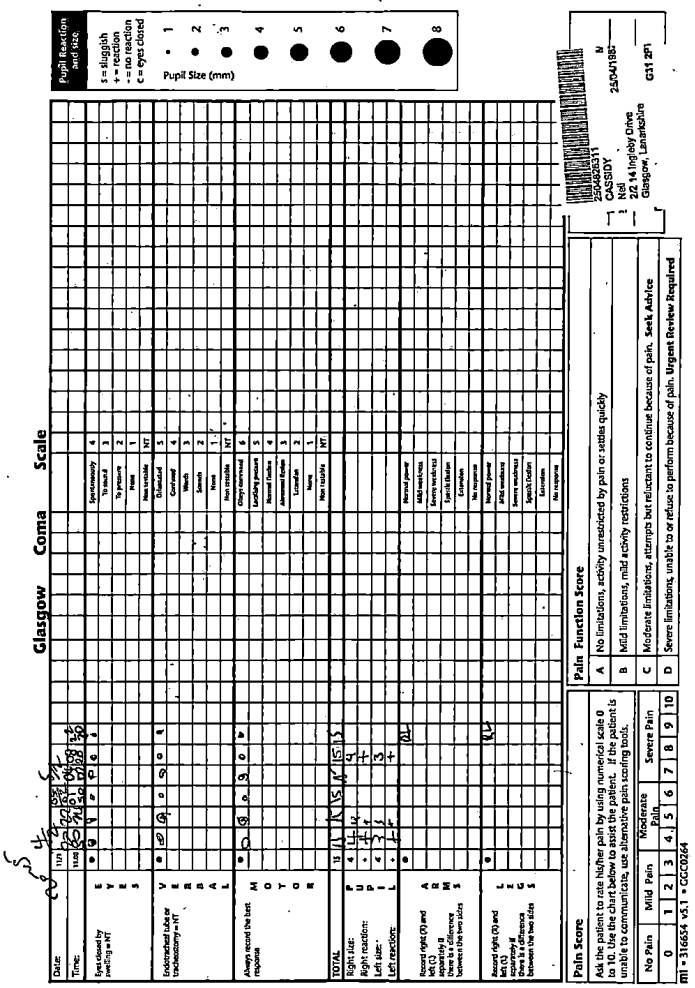
Discontinuation of NEWS

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

Signed.....

Medical: .....

Date: .....



Neil 2
Cassidy

NEWS 2 Key	1	2	3

2504826311
CASSIDY M
Neil
2/2 14 Ingleby Drive
Glasgow, Lanarkshire 25/04/1982
G31 2PT

Date	1/11
Time	11.00

A + B Respirations Breaths/min

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

A + B SpO2 Scale 1 Oxygen saturation (%)

First recorded value: 97

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

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

Only use scale 2 under direction of qualified clinician

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

Air or oxygen?

First recorded value: A

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

C Blood Pressure mmHg (Score uses systolic BP only)

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

C Pulse Beats/min

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

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

Level	Score
A Alert	0
C New Confusion	3
V Verbal	3
P Pressure	3
U Unresponsive	3

E Temperature

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

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

Abbreviations for recording oxygen device

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

2504826311
CASSIDY M
Neil
2/2 14 Ingleby Drive
Glasgow, Lanarkshire 25/04/1982
G31 2PT

NEWS > 4 THINK SEPSIS
Apply SEPSIS 6 within 1 hour

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

Think ACE

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

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

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

NHS Greater Glasgow and Clyde

Greater Glasgow and Clyde Occupational Therapy Stroke Service- Short Assessment

Name: Neil Cassidy CHI No: 2504826311 Hospital: GRI Ward: 53 HASU Consent: X Risk Ax: X Date/Time of Ax: 07/02/2025 at 10am	Diagnosis/CT Result: Right medial occipital infarct as shown on CT. Further areas of infarction are present in the right thalamus and hippocampus which I can not clearly identify on CT from 4-2. No haemorrhage. No substantial background white matter disease. No other findings of note. Date of Admission: 04/02/2025 PMH: (include relevant allergies)

HPC: Left visual field impairment and left side mild sensory and strength Pt Expectations: to be discharged home after CTA scan	Social Hx: lives in 2nd floor flat with 12year old son, son has autism and patient is main carer for son as as sons mum passed away. Patinet usually independent with all ADL, non driver, does not go out much except to walk dog, shopping. Family, sister and brothers very supportive helping out at present with looking after son and dog while he is in hospital. Manages household ADL tasks and carers for son, getting him up and ready for school, school bus takes patinets son to / from school

Hand Dominance R ☐ L☐		Intact Yes	Intact No	Comments
Upper Limb	Power	X	☐	
	Sensation	☐	X	Minimally altered
	Co-ordination	☐	X	Min reduced
	Proprioception	☐	☐	Using UL fully functionally in task
Vision		☐	X	Left VF inferior R upper quadrant on confrontation and STAR cancellation. Double vision – temporay plaster patches provided for reading and doing household tasks
Communication		X	☐	
Feeding		X	☐	
Self care		X	☐	
Functional transfers/ mobility		X	☐	
Kitchen		X	☐	Advice given regards managing VF impairment
Extended ADL's		☐	X	Family support

Driver: Yes ☐ No X Driving Advice provided: Yes ☐ No ☐ N/A X Leaflet ☐

Comments:

NHS Greater Glasgow and Clyde

Greater Glasgow and Clyde Occupational Therapy
Stroke Service-
Short Assessment

Cognitive Screen:

Question	Yes	No	U/A	Comments
Accurate initial interview information given?	X	☐	☐	
Orientation (Day, Date, Month Year, Place)	X	☐	☐	
Medical plan recalled (Past/Prospective)	X	☐	☐	
Insight	X	☐	☐	

Demonstrate use of technology (Tick device assessed)

Phone X Tablet ☐ TV ☐ Laptop ☐ U/A ☐

Comments: some difficulty, taking time, advice given due to vision

Further cognitive assessment required? Yes ☐ No X Comments:

Cognitive leaflet issued? Yes X No ☐ N/A ☐

Plan:

D/C no follow up ☐ D/C with Self-Management ☐ D/C with follow up X orthoptic referral

Discharge Summary:

Independnet with ADL at ward and functional transfers and mobility.

Vision:
On ax appears to have inferior left upper quadrant visual field impairment. Min impacting on function, Diploia, temporary plaster eye patches given to help support in task, advised not to wear patch at all time.

No OT CST required.

Patinet to be referred to orthoptist for ax as OP. Will be referred via referral management and copy of referral also sent to orthoptist's at Stobhill

Patinet discharge from OT at GRI HASU

Staff name Laura Gordon Designation B7 OT Date/Time 07/01/2025 4pm