CRISIS NURSE REFERRAL FORM – CAITHNESS CMHT

Complete & fax referral to 01955 606916
Telephone 01955 606915
Referral & risk assessment form to be completed before Crisis Intervention can be considered. Please ensure you complete requested information when making a referral. Thank you.

SURNAME Kerr **FORENAME(S)** Colin

DATE OF BIRTH 29/11/79 **CHI** 2911796454

ADDRESS 20 Bracken Lane, Stirling, FK9 5NB

TEL. NUMBER 07599321854 **MARITAL STATUS** Married

OCCUPATION Chef

GP Dr Clark, Braes of Allan **TEL NUMBER**

REFERRER DETAILS (IF DIF FROM GP)

HAS REFERRAL BEEN DISCUSSED WITH CLIENT? (YES) NO

IF NO, WHY?

ANY PREVIOUS CONTACT WITH MENTAL HEALTH SERVICES? YES (NO)

If yes please detail where and when:

CURRENT MEDICATION Nil on repeat prescription. commenced onto diazepam + thiamine on admission

REASON FOR REFERRAL Recently fired from Mackays hotel after found taking heroin + drinking alcohol. Patient refused to leave Mackays hotel after being fired so police had to escort patient from premises. Patient then stated he has been having suicidal thoughts + was taken to A+E by police.

RISK ASSESSMENT ON PAGE 2 MUST ALSO BE COMPLETED

RISK ASSESSMENT CRITERIA (to be completed for all crisis referrals)

RISK OF SELF HARM: overdose, mutilation etc

Current Risks... Drug + alcohol abuse. £50 worth of heroin + 2 bottles of vodka over 2 days.

Historical... Heroin user 5 years ago.

Suicide attempt of cutting wrists.

VIOLENT BEHAVIOUR: current presentation / previous episodes, convictions etc

Current Risks: nil known

Historical

SUICIDAL IDEATION: current plan, access to method etc Any previous attempts

HAS STORM ASSESSSMENT BEEN COMPLETED (Y) N (attach if yes)

Current Risks... Suicidal thoughts

Historical ...cut wrists

SELF NEGLECT: hygiene, appearance, weight loss etc

Appears presentable at present.

NON COMPLIANCE WITH MEDICATION only started on diazepam + thiamine today (23/10/17) and has taken with no issues.

ALCOHOL / OTHER SUBSTANCE MISUSE current / ~~previous~~

2 bottles of vodka over 2 days.

ANY OTHER RELEVANT INFORMATION Recent split from wife as starting using heroin again.

No current abode

Completed by: KLuth Date: 23/10/17.

Date:

fax - 606 916

CONFIDENTIAL
SELF REFERRAL FORM
CAITHNESS ALCOHOL AND DRUG SERVICE (CADS)

If you would prefer not to fill in a form or you wish to speak to one of us in confidence please contact a member of our team by either telephoning 01955 606915 or 01847 891224 and ask for the Alcohol and Drug Service.

Name: Colin Kerr	Telephone Number: 07555 282460	Date of Birth: 29/11/79
Address: ~~N/A~~ - homeless		

Please let us know a little about why you are referring yourself to the service:

Drug abuse + alcohol abuse.
£100 heroin per day + 2 bottles of vodka. Hospital prescribed me some valium which helped a little and now want to discharge me which inevitably will lead back to square 1.
See police report.

How would you prefer to be contacted by a member of the team? (√)	Telephone:	Letter:

Please hand this form or post to either:

CMHT(CADS)
Old Medical Centre
Bankhead Road
Wick
KW1 5LB

CMHT (CADS)
Old Outpatients Department
Dunbar Hospital
Thurso
KW14 7XE

A member of our team will then contact you by your preferred method and invite you to come and speak with one of us so you can tell us more about your concerns and we can talk about how we may be able to support you.

Accident and Emergency Department
Caithness General Hospital

16000006314

2911796454

Surname	KERR	**First Name**	COLIN	**Title:**	
Address:	20 BRACKEN LANE	**Postcode**	FK9 5AB	**CHI No:**	2911796454
	STIRLING	**Telephone:**			
Date of Birth:	29.11.79	**Sex:**	M	**Age:**	37 yrs

CHI Barcode:

GP Name:	Clark Claire		
Address:	Bridge Of Allan Health Centre Fountain Road Bridge Of Allan	**Postcode**	FK9 4EU
		Telephone:	01786 833210

Next of Kin Leanne Kerr
Relationship: ~~partner~~ wife.
Address:
Postcode
Telephone: 01786 358392 (work)
07762 772437

Date of Attendance: 23.10.17 14:10
Date of Incident:
Presenting Complaint: FEELING UNWELL

Triage T3 7 4.

Tetanus Cover:

Allergies:

P= **BP=** / **RR=** **Sat=** **GCS=**

Drugs Prescribed

Date	Drug	Dose	Route	Signature	Given By	Time

A&E No. 16000006314 KERR COLIN Date of Birth: 29.11.79

Date: 23.10.17 14:10 Time Seen: Seen By: UM

CHI No: 2911796454

- Attended ED after being taken to the department by the police after having to be physically removed from Macdays Hotel after being sacked from his position and then refusing to leave. Stating suicidal ideation to police and states he will throw himself of a building.
Social - no fixed abode at present recently separated from wife. Has children
PMH - Previous suicide attempt (cut wrists)
Med - Omeprazole.
Allergies - NKDA
- Clean from heroin for 6yrs after a 5yrs habit
- Recent seperation from wife due to drug abuse
- States he has been drinking 2 bottles of vodka daily over the past 3 days.
- Up in the area for a job but felt unable to work yesterday and has been withdrawing from heroin due to availability in the area and has gone from a £100 a day habit over the past 5 weeks to a £50 over 2 days over the past week.
- Recent admission to A+E in Sterling (3wks ago) after threatening to kill himself by jumping off a building.
- Feels nauseated due to withdrawal.
- Talkative and open re. past + present position.

Caithness General Hospital

EMERGENCY DEPARTMENT CLINICAL RECORD

CHI Barcode:

SURNAME	CHI	SEX
KERR	2911796454	M
First Name	D.O.B.	AGE
COLIN	29 NOV 1979	37
ADDRESS: STREET		
20 BRACKEN LANE		
SUBURB	POSTCODE	
STIRLING	FK9 5AB	

CHI No: 2911796454

Treating Doctor: WYBREW, ROBIN Time Seen: 15:00 Date Seen: 23 OCT 2017

Primary Diagnosis: Z91.5 SELF HARM - PERSONAL HISTORY OF SELF-HARM

Addt. Diagnoses:

Consultations:

Investigations:

Procedures:

Departure Destination:

Departure Status: ADMIT TO MEDICAL

Referred to on Departure: ROSEBANK WARD

Departure Ready Time: Date:

Actual Departure Time: Date:

Clinical Notes:

23 OCT 2017 15:16 LYNSAY MOFFAT
SITUATION

THIS IS COLIN KERR A 37 YEAR OLD GENTLEMAN WHO ATTENDED ED BY POLICE ESCORT FOLLOWING AN INCIDENT TODAY WHERE HE HAD TO BE PHYSICALLY REMOVED FROM THE MACKAYS HOTEL AFTER BEING DISMISSED FROM THERE EMPLOYMENT AND REFUSING TO LEAVE. WHILST IN POLICE CARE HE EXPRESSED FEELING OF SUICIDAL IDEATION AND STATED HE WAS GOING TO THROW HIMSELF OFF A BUILDING. ALCOHOL INTOXICATED AT TIME OF INCIDENT AND HAS A RECENT HISTORY OF HEROIN ABUSE OVER THE PAST 5 WEEKS AND IS EXPERIENCING WITHDRAWAL AT PRESENT.

NEWS 0

BACKGROUND

PMH- PREVIOUS SUICIDE ATTEMPT BY CUTTING HIS WRISTS BUT WAS NOT DETAINED, CLEAN FROM HEROIN FOR 5YEARS BUT 5 YEAR HISTORY PRIOR TO THIS.

ALLERGIES-NKDA

SOCIAL- NO FIXED ABODE AT PRESENT AS HE HAS SEPERATED FROM HIS WIFE DUE TO HIS RECENT RETURN TO USING HEROIN. HAS CHILDREN ALSO WHO ARE IN THE CARE OF THERE MOTHER.

MEDICATION-OMEPRAZOLE

ASSESSMENT

RECENT SEPERATION FROM WIFE DUE TO RETURN TO DRUG USE AND HAS RECENTLY SOLD HIS BUSINESS.

Emergency Department Clinical Record

UP IN THE AREA FOR A JOB BUT FELT UNABLE TO WORK DUE TO WITHDRAWING FROM HEROIN DUE TO REDUCED AVAIBILITY IN THE AREA AS HE WAS USING DAILY £100 (2G) HABIT BUT HAS HAD TO REDUCE TO £50 (1 G)EVERY 2 DAYS SINCE COMING TO THE AREA DUE TO LACK OF SUPPLY BUT MANAGED TO GET SOME SENT UP.
STATES HE HAS BEEN CONSUMING 2 BOTTLES OF VODKA PER DAY OVER THE PAST 3 DAYS DUE TO LACK OF DRUG AVAILABILITY.
HAS CONSUMED 1/4 OF A BOTTLE OF VODKA TODAY BUT FULLY ALERT AND ORIENTATED.
RECENT ATTENDANCE AT ED IN STIRLING 3 WEEKS AGO DUE TO SUICIDAL INTENT AND THREATENING TO JUMP OFF A BUILDING BUT WAS NOT DETAINED.
TALKATIVE AND OPEN RE PAST AND PRESENT SITUATION AND FRANK RE DRUG AND ALCOHOL USE.
FEELING NAUSEATED DUE TO WITHDRAWAL FROM HEROIN AND LAST HAD A FIX 2 DAYS AGO.

RECOMMENDATIONS

ADMIT TO RBW FOR TREATMENT FOR WITHDRAWAL AND REFERRAL TO MHT FOR ASSESSMENT

Signature

First Name
Fi
C
(or
Al

NHS
Highland

Date document started : 23/10/17

Caithness Medical
Common Admission Document

Lead Reviewer - Duncan Scott, Consultant Physician

Medical Assessment **Clerking**
Common Admission Document

NHS Highland

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Admitting Consultant : Ahmad ..

Date : 23 / 10 / 2017 Time of assessment :

Name of middle grade doctor/other McBrow Bleep :

Designation NP ☐ FY 1 2 ST 1 2 3 4 5 6 7 Other : ACP.

37 ♂

PC : Suicidal.

HPC : Brought in by police:- was working as a chef in McDonalds but not turning up to work as incidental on heroin & alcohol. Was addicted to heroin 5yrs until 2012 - stopped. Resumed heroin 5/52 ago:- he put his business up for sale on facebook whilst drunk & sold it a week ago; simultaneously walked out on wife & family to come and work as a chef here. Now full of regrets as business was going well & marriage was fine until started drugs & alcohol again 5 weeks ago. Talks as if wants his life to end but not made any plan but he is willing to tell consultant - has accepted admission because he wants to get things right again - "perfect" as he says being back with wife & kids and working.

(To be filled in by doctor at time of examination)		
Resps		Bpm
O_2 Sats		%
FiO_2		%
Temp		°C
BP		mmHg
Pulse		bpm
A	V	P	U
NEWS Total		
>7, tell senior doctor		

PMH	No	Yes	Details (dates, severity,etc):
MI	☑	☐	
Angina	☑	☐	
↑BP	☑	☐	
Dementia	☑	☐	
COPD	☑	☐	
Asthma	☑	☐	
Stroke	☑	☐	
TIA	☑	☐	
Diabetes	☑	☐	
Epilepsy	☑	☐	
CKD	☑	☐	Stage :

Remember to access key information summary (KIS) on ECS

Other PMH : Reflux. Dermatitis.

McDonalds asked him to leave; when police came to evict him he said he would jump off a bridge so they took him here.

Social History Occupation U/E... had a removals business. walked out on wife.

Other social issues :

Housing : Lives alone? Yes ☐ No ☐ Own ☐ Shelt. ☐ RH ☐ NH ☐

Social Care : ....

Driver : Yes ☐ No ☐

Smoking : Never ☐ Ex ☐ (stopped......years) Current ☐ /day

Alcohol : None ☐ No. of units/week 2 BOTTLES SPIRITS A DAY. Previous excess ☐

If one or more ticked please refer to MHLT. Women > 6U at once ☐ Men > 8U at once ☐ Alcohol 5/7 ☐

Drug History (Medicines Reconciliation)

Remember: The commonest error leading to patient harm is mistakes in prescribing current medications. Cross-check all available sources.

Patient Details:

Mandatory Three Source(s) of History: (Unobtainable / Checked)

1. ☐ ☑ Emergency Care Summary*
2. ☑ ☐ Patient or Relative
   ☐ ☐ Patient's Own Drugs

*** Plus one below if ECS unavailable or inappropriate for use:**

- ☐ GP Referral Letter
- ☐ GP Surgery
- ☐ Other Hospital/Nursing Home Drug Chart
- ☐ Other: .....

3 ADMISSION MEDICATION: NONE ☐ Or:

(NB Check for specialist prescribed medicines e.g. chemotherapy)

Name, Form/Route	Dose	Frequency	Indication (if known)	ACTION Hold	Stop	Change	Comments (if medication held, stopped or changed) & Start Date if short course
OMEPRAZOLE	?	?	?				

ACTION Note: Unless indicated to stop/hold, medication should be continued on drug chart/discharge.

4 NON-PRESCRIPTION MEDICATIONS, HERBAL MEDICATION AND ILLICIT DRUGS: NONE ☐

5 Adverse reactions / Allergies (This section is always mandatory)

Info. unavailable ☐

No Known Drug Allergies ☐ OR

Drug/Substance:	Reaction:	Drug/Substance:	Reaction:
MEDS			

(For surgical patients, remember to include side-effects seen in the peri-operative setting)

Are you satisfied this medication history is complete (1 2 3 4 5) and accurate: Yes ☑ No ☐

If "no", what further action is necessary (contact GP, access ECS, as for pharmacist review, etc)

Reviewed by pharmacist -	Name:	Signature:	Date:

Medical Assessment
Common Admission Document

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Cognitive Assessment 4AT

(1) ALERTNESS

Normal (fully alert but not agitated, throughout assessment)	0
Mild sleepiness for <10 seconds after waking, then normal	1
Clearly abnormal	4

(2) AMT4
Age, date of birth, place (name of the hospital or building), current year.

No mistakes	0
1 mistake	1
2 or more mistakes/untestable	2

(3) ATTENTION
Ask the patient : "Please tell me the months of the year in backwards order, starting at December."
To assist initial understanding one prompt of "what is the month before December?" is permitted.

Months of the year backwards. Achieves 7 months or more correctly	0
Starts but scores <7 months / refuses to start	1
Untestable (cannot start because unwell, drowsy, inattentive)	2

(4) ACUTE CHANGE OR FLUCTUATING COURSE
Evidence of significant change or fluctuation in: alertness, cognition, other mental function (eg. paranoia, hallucinations) arising over the last 2 weeks and still evident in last 24 hrs

No	0
Yes	4

4 or above : possible delirium +/- cognitive impairment
1-3 : possible cognitive impairment
0 : delirium or cognitive impairment unlikely (but delirium still possible if [4] information incomplete

Total 0
4AT Score

Systematic Review

Respiratory

Cardiovascular

GI

GU

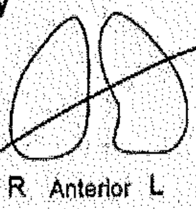
CNS

Locomotor

Other Hx - Sexual, Family, Travel
① INJECTING HEROIN — USES CLEAN NEEDLES
② MAT AHART THYROTOXICOSIS & TED

Clinical Examination

Respiratory



Ø. clear

Peak exp. flow
(if appropriate)

CVS Pulse regular ; rate 110.

HS : I+II+0

Abdomen

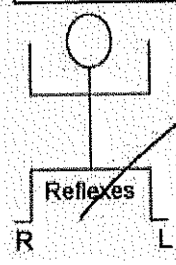
SNT. OLHKS.

PR :

CNS

	RUL	LUL	RLL	LLL
Tone				
Power				
Sensation				

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



Cranial nerves :

Gross N.

General Examination: (skin, endocrine, musculoskeletal)
Sweats. essential tremor

Venous Thromboembolism Prophylaxis Assessment Protocol use for patients aged 16 and above

Day case local anaesthetic procedure without sedation, children under the age of 16 & pregnant women admitted directly to the obstetric unit.

VTE Prophylaxis not required Exit protocol ☐

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1. Assess Risk

Age > 60	
Obesity (BMI > 30kg/m^2)	
Active cancer or cancer treatment	
Anticipated significantly reduced mobility for 3 days or more	
Known significant medical co - morbidity e.g. symptomatic heart failure, chronic respiratory disease, chronic inflammatory condition	
Thrombogenic medication i.e. hormone replacement therapy, oestrogen containing oral contraceptives, tamoxifen, raloxifene, cyproterone	
Personal history of, or first-degree relative with a history of VTE	
Confirmed or suspected sepsis	
Acute surgical/gynaecological admission with inflammatory or intra-abdominal condition	
Continuing pregnancy or < 6 weeks post partum	
Extensive varicose veins	
Femoral vein catheter	
Lower limb plaster cast	
Orthopaedic trauma including pelvic, multiple long bone, hip fractures, lower limb fractures and dislocations	
Any higher risk surgical procedure (any surgical procedure not defined as lower risk) *Examples of lower risk surgical procedures are listed in box below*	
Lower risk surgical procedures e.g Excision of skin lesion /soft tissue lump (incl. head neck and face) laryngoscopy, vasectomy, release of carpal tunnel, manipulation of fracture, injection/aspiration of joint, hysteroscopy/gastroscopy/ colonoscopy and biopsy, endometrial ablations, vulval procedures and STOP etc	

For Full list of lower risk surgical procedures see VTE Prophylaxis Assessment Protocol Guide; Intranet policies library

1 or more ticks Go to Step 2 ☐ | No ticks Anticoagulant NOT required Go to Step 3 ☐

2. Assess Contraindications (tick all that apply)

Active bleeding	
Acute head injury	
Acquired bleeding disorders (e.g. acute liver failure)	
Full anticoagulant therapy at time of admission (excluding anti-platelet agents)	
Acute stroke within 14 days	
BP above 230/120 mmHg (systolic or diastolic)	
Thrombocytopenia (<75 x 10^9/L) result _____ date _____	
Untreated inherited bleeding disorders i.e. haemophilia or von Willebrand disease	
Head & neck/ENT surgery: thyroid, parathyroid, parotid, tonsil, middle ear or nasal surgery	
Ophthalmic surgery - all procedures	
Dental Extractions	
Urology - TURBT, TURP	
Neuro-surgery : all procedures	
Spinal surgery : all procedures	
Non operative high bleeding risk procedure e.g. liver, renal & lung biopsies & all radiological guided biopsies	

Prescribe ENOXAPARIN 40mg daily ☐
OR
If eGFR is <30 or body weight <50kg
Reduced dose of ENOXAPARIN 20mg daily ☐
(see dosage instructions below)

No ticks

1 or more ticks ☐ **DO NOT prescribe enoxaparin**

DO NOT
administer anti-coagulant if a lumbar puncture, epidural, spinal or regional anaesthetic block is expected within 12 hours or has been performed in the previous 4 hours

3. TED Stockings Assess exclusion criteria

Orthopaedic or medical patient	
Pulmonary oedema (e.g. heart failure)	
Severe peripheral neuropathy	
Severe peripheral arterial disease	
Massive leg oedema	
Cellulitis / ulcers	
Dermatitis	
Major leg deformity	
Acute stroke within past 14 days	

No ticks Prescribe TEDS ☐ | 1 or more ticks TEDS not required Do not prescribe ☐

4. Indicate below which results were available (SCI store must be checked)

Platelet count Available ☐ Not available ☐ Date 22/11/17
eGFR results Available ☐ Not available ☐ Date 23/11/17

5. Sign and date

Name [illegible]
Signature [signature]
Date 23/11/17 **Time** 15:30

Comments / Variance to protocol

Name :
Signature :
Date: **Time:**

Dosage Instructions: Always Prescribe Enoxaparin for 1800 administration
If VTE assessment is completed between 1800 and 0600 administer first dose straight away, then 1800 thereafter.

Medical Assessment
Common Admission Document

Initial Problem List and Plan

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Problem List / Differential Diagnosis

1. recent return to heroin / alcohol.
2. FH of Thyrotoxicosis / PTSD.
3. Social

Plan Admit:- Detox EtOH c̄ Diazepam. He does not wish to continue c̄ opiates and does not want methadone. Has to dose steadily over last week.

Plan	Requested		Requested
• Bloods	☐	•	☐
• ECG	☐	•	☐
• CXR Not required ☐	☐	•	☐
•	☐	•	☐
•	☐	•	☐
•	☐	•	☐
•	☐	•	☐
•	☐	•	☐
•	☐	•	☐
•	☐	•	☐
•	☐	•	☐
•	☐	•	☐
•	☐	•	☐
•	☐	•	☐
•	☐	•	☐

Antibiotic

Date :.................... Time :....................

Indication....................

Samples sent (specify)....................

Pathogen known? Y / N - Organsim....................

Antimicrobial Details :....................

New Change Reason for change....................

Duration of therapy.......... Review Date..........

REVIEW FOR IV TO ORAL SWITCH AT 48 to 72 HOURS

Decision for therapy made by (name, grade, bleep) :

....

Outwith management of Infection Guidance? (specify why):

....

Clerking complete including Med. Rec, VTE and Plan. Signed [signature]

(Note: name and bleep number must appear at the front of the clerking)

Medical Assessment
Common Admission Document

Results - Please document all investigations this admission

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Results (NOTE : It is important to document times when results are recorded and to initial in the box provided)

	Initials	Time
ECG		
Subsequent ECG		
CXR		
Radiology		
Phoned Microbiology Result		

Previous	Blood Results											
	Date	23/10										
	Sample Time	15:15										
	Initial	VR										
	Na	140										
	K	4.2										
	Chl	105										
	Bic	30										
	Urea	4.6										
	Creat	67										
	eGFR	>60										
	Bil	6										
	ALP	81										
	ALT	28										
	Alb	46										
	A.Ca											
	Glucose	5.5										
	Magnesium											
	Phosphate											
	CRP	12										
	Trop.											
	Lactate											
	Amylase											
	Hep B	~~awaited~~										
	Hep C	awaited										
	HIV	awaited										
	Hb	171										
	MCV	94.4										
	Platelets	362										
	WCC	8.1										
	NPhils	6.5										
	lymph	1.2										
	eosin											
	PV											
	PT											
	PTT											
	Fibr											
	INR											
	TSH	0-30										
	Free T4	11.4										
	Date											
	Time											
	FiO_2											
	pH											
	pCO_2											
	pO_2											
	Bicarb											
	BE											

Urinalysis			
Leuk		Ket	
Nitr		Urobil	
pH		Bil	
Prot		Blood	
Glu		Hb	
		MSU sent	☐

Medical Assessment
Common Admission Document

Consultant Ward Round

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Name :

Date : / / 20

Time :

ECG

CXR

Other

Deteriorating patient : Treatment escalation plan

Full escalation ☐ or see TEP ☐

Signature :

Name : Bleep

Interim Codes for Inpatient / Daycase Waiting List Procedure Coding

Code	Description
WTS020	WTS General Inpatient/Day Case (84 days)
WTS045	WTS Cancer Decision to Treat (31 days)
WTS050	WTS GI SCope & Cystoscopy (28 days)
WTS021	WTS Cataract (1st Eye) (63 days)
WTS022	WTS Cataract (2nd Eye) (84 days)
WTS030	WTS Heart Disease (Cardiac excl Diagnostic Coronary Angiogram) (63 days)
WTS031	WTS Heart Disease (Diagnostic Coronary Angiogram) (28 days)
WTS051	WTS Respiratory Sleep Studies (42 days)
WTS000	WTS non new ways waiting list only no guarantee date

Consultant Ward Round Checklist :

Patient Name.....

Date.....

	Seen/ Done	N/A	Awaited/ Comment
Bloods			
ECG			
CXR			
Oxygen Prescribed			
Antibiotic Sticker			
Ceiling of Therapy			
VTE Prophylaxis considered			
Diagnosis and plan stated by consultant			
Medicines Reconcilliation - steps 1-5 completed			Assign to Dr.....

STORM

Assessment Work Sheet

Name: Colin Kerr Date: 23/10/17

Signature: CKerr Review date:

Suicidal Intent

Wishes to be dead
Fleeting / fixed / Frequency
Hopelessness / View of the future
Current perception

Colins view of the future is poor, he feels like he has lost everything, his wife and business and he doesnt know of a way to get it all back.

Plan

Is it a detailed plan?
How / When / Where / Means
Immediate intention
Measures to prevent detection

Not a detailed plan - he stated he'd likely find the tallest building + jump off.

Background

Events leading up to crisis
Events in last 48 hrs if after an attempt
Past history of self harm/suicide

Drug/alcohol abuse since teenager. Girlfriend died of heroin overdose + their 7 year old daughter taken into social care. Has then since been in Rehab for 18 months. Colin met his current wife + they built a ~~business~~ business together but an unknown trigger a few months ago made him use heroin again which caused his wife to leave him + throw him out the house. He now has no current abode.

Factors which make suicide more or less likely

Gender / Ethnicity
Drugs / Alcohol
Mental illness

Protective factors

- Drugs + alcohol.
- no current abode
- no support from family/ friends.
- previous suicide attempt.

Coping Mechanisms

What worked to ease crisis/problems in the past?
What stopped suicide being completed - now & in the past?

- Colin states his coping mechanism was drugs + alcohol.
- He thinks about getting back with his wife which has stopped him from suicide

Crisis Management

Before going on to manage the crisis:
Have all the elements in assessment been covered sufficiently?

Alison Smith

Short Stay Assessment & Care Plan 6095 44

For people in hospital 72 hours or less

Does the person have Complex Care Needs?	Y / (N)	**If YES to any of the questions on the left, proceed to full NHS Highland Activities for Living Assessment & Nursing Care Planning Record**
Is the person likely to require a change to their care package on discharge?	Y / N / (NA)	
Evidence of frailty using frailty screening tool?	Y / N / (NA)	
Falls risk? Yes to any of the following: 1. Has the person fallen in the last 6 months - including during this admission? 2. 4AT greater than 1? 3. Attempts to walk alone is unsteady or unsafe? 4. Does patient/relative have anxiety re: falling? 5. In your clinical opinion, is the person at high risk of falling? 6. Is the person unable to reliably use the call bell to summon assistance?	Y (N)	
Is the person likely to remain in hospital for 72 hours or more?	Y / (N)	
eir ability to manage ADLs?	Y / (N)	

Name of Hospital Ward: RBW

Date: 23/10/17 Time:

Admitted From: A & E ☑ GP ☐ LIST ☐ Other ☐ (specify).....

Admitting Nurse: LYNDAY MOFFAT Admitting Consultant / GP: Amen

Room / Bed number (mark in boxes below if person is moved)					**Next of Kin Details**
Bed No.					**NOK notified: Y / N / NA** **Time:**
Date:					Name: Leanne Kerr
Likes to be known as:	Colin				Relationship: wife
Religion:					Telephone No: 01786 358 392 (work)
GP:	Dr Clark, Bridge of Allan				07762 772437

Admission Reason:	**Individual's Understanding of Reason for Admission:**	**Relevant/Past Medical History:**
Suicidal ideation Withdrawal from heroin + alcohol	aware	Previous suicide attempt (cut wrists)

DNA CPR certificate	Y (N)	**Date started**	
Medication brought in	Y / (N)	**Where stored?**	
Allergies:	Y / (N)	**Details**	
Personal effects/ valuables brought in	Y / N	**Details**	

Valuables Disclaimer

NHS Scotland regrets it cannot take responsibility for any clothing, belongings or valuables kept by people in hospital. I have been given the opportunity to have valuables kept in safety but have opted to keep items for personal use. I accept responsibility for my own clothing, money and valuables.

Name: **Signature:** **Date:**

DISCHARGE/TRANSFER PLANNING		**Comments**	**Initials**
Estimated Date of Discharge			
SBAR transfer completed?			
Next of Kin contacted?	Y / N / NA		
Social Services Contacted?	Y / N / NA		
Transport Details:			
Medication given?	Y / N / NA		
Medication explained?	Y / N / NA		
Letters?			
Any referrals:			
Valuables returned	Y / N / NA		

Activities for Living Assessment.

To be completed in conjunction with mandatory assessments.

Name : (or attach label)

CHI Number :

1. Keeping Safe	Normal status Y/N/NA	Current status Y/N/NA	Additional Information			Care Plan Number
Independent (able to cope safely in ward environment)	Y	N	Suicidal ideation withdrawal from heroin/alcohol.			
Waterlow (enter score)						
Alert / orientated	Y	Y				
Falls risk	N	N				
Smoker NHSH has a no smoking policy and smoking is not permitted during your stay	N	N	Offered NRT: Y / N	Smoke free advisor offered? Y / N	Smoke free advisor accepted? Y / N	
2. Communication						
Hearing, Vision, Speech & Language (circle as required)	N	N				
3. Breathing						
Any problems	N	N				
Short of breath at rest	N	N				
Short of breath on exertion	N	N				
Breathless at night	N	N				
Home O2/Home nebuliser	N	N				
Cough	N	N				
4. Washing, Dressing & Oral Care						
Independent with all aspects	Y	Y				
Other - specify						
5. Eating & Drinking						
Healthy appetite	Y	Y	BMI		Weight	
Requires support to eat/drink including help or equipment	N	N				
Signs or risk of dehydration	N	N	Complete hydration assessment within 6 hours of admission			
Swallowing issues	N	N	Eating and drinking risk assessment required Y / N			
Fasting / Nil by mouth	N	N	Implement Nil By Mouth SOP immediately			
Food & drink allergies/intolerances or special (therapeutic diet) - including texture modified and/or supplements & religious or cultural dietary requirements, likes/dislikes						
Alcohol - weekly consumption - units: daily 25 units			ABI required: Y / N		ABI delivered: Y / N	
6. Pain						
Pain free		Y				
Is pain management required whilst in hospital?			*Additional information*			
7. Elimination						
Independent		Y				
Urinary/faecal incontinence						
Indwelling catheter						
Stoma						
8. Keeping moving						
Independent (walking)		Y	Use of Aids - Specify:			
Physically active?			National recommendations - 30 minutes per day or 150 minutes per week moderate exercise			
9. Sleeping						
Any problems?		N				
Do you have any money worries?			Highlight Citizen Advice Service			

10. Assessment Findings and Summary of Planned Actions. Give a brief overview of clinical assessment findings and any specific clinical care needs - which are detailed in the person-centred care plan.

Emergency admission via ED with history of suicidal ideation and withdrawal from heroin + alcohol.

Signature: [signature] Date/Time: 23/10/14 1545.

PECOS
No.
WZS136

NHS Highland Mandatory Nursing Assessments

NHS Highland

CHI: 2911796454

KERR
COLIN
M 29/11/1979 R773621
20 BRACKEN LANE
STIRLING
FK9 5AB

Date / Time of admission :

Index of mandatory assessments
Page 2 & 3 : Infection risk assessment
Page 4 : Bedrails
Page 5 : Moving & Handling
Page 6 & 7 : Waterlow and Foot assessment
Page 8 : MUST

Guidance for completion of assessments
Infection Control assessment - complete for all patients on admission
Bedrails assessment - complete for all patients on admission
Moving & Handling - complete for all patients on admission
Waterlow - to be completed for all patients within 6 hours of admission
MUST - to be completed for all patients within 24 hours of admission

As required assessments (available as single sheets on PECOS)
Falls Bundles
Delirium / TIME Bundles
Frailty Screening
Continence
Peripheral Vascular Catheter
CVC / PICC
CAUTI
Oral Health Assessment
Eating & Drinking Risk Assessment
Wandering Patient Assessment
Bariatric Assessment
MDT Risk Assessment
Sepsis Bundle

Reference:	Date of issue: October 2016
Prepared by:	Date of review: June 2017
Lead Reviewer : Alison Hudson	Version: 21
Authorised by:	Date:
EQIA (Equality Impact Assessments):	EQIA Date:

THIS DOCUMENT MUST FOLLOW THE PATIENT

Name : (or attach label) CHI Number :	**In-Patient Infection Prevention Risk Assessment**
Hospital & Ward/Dept:	**Date:**

Is the patient in any of the following groups (1-3 below)?

N.B.

SCREENING AND THE OUTCOME OF RESULTS MUST BE DISCUSSED WITH THE PATIENT (AND AS APPROPRIATE THEIR RELATIVES/CARERS) AND RECORDED IN THE FAMILY DIALOGUE SHEET.

PATIENTS ADMITTED TO ITU, RENAL, ORTHOPAEDIC & VASCULAR TO HAVE A ROUTINE SCREEN FOR MRSA.

1. MULTI-DRUG RESISTANT RISK ASSESSMENT	Yes	No
1: Transferred from any hospital outside Highland		✓
2: Hospitalised outside Scotland in last 12 months		✓
3: Holiday patient from outside NHS Highland needing dialysis / Dialysis patient returning from holiday outside NHS Highland		✓
4. Previously known *CPE/VRE colonisation / infection		✓

If **YES** to any of the questions the patient is at increased risk of CPE/VRE carriage →

ISOLATE - if not possible discuss with the Infection Control Team
Date:
Signature:

FOR CPE SCREEN:
Obtain rectal swab (blue topped except Argyll & Bute, Red Top)
Label specimen
Date:
Signature:

FOR VRE SCREEN:
Screen rectal swab or stool specimen and any other manipulated sites e.g. wounds / ulcers.Label specimen
Date:
Signature:

*CPE: Carbapenemase producing Enterobacteriaceae
*VRE: Vancomycin-resistant Enterococcus

2. MRSA CLINICAL RISK ASSESSMENT	Yes	No
1: Is patient previously MRSA positive? (ask the patient/check patient information systems)		✓
2: Has the patient come from another hospital or care home?		✓
3: Does the patient have: Wound/ulcer, or invasive device present/removed in last 7 days		✓

If **YES** to any of the questions:

SCREEN FOR MRSA

and isolate as per policy →

Screen patient, obtain swabs:
NASAL:
PERINEUM:
OTHER (identify):

Date of screening:
Signature:

THIS DOCUMENT MUST FOLLOW THE PATIENT

Name : (or attach label)

CHI Number :

In-Patient Infection Prevention Risk Assessment

3. DIARRHOEA AND/OR VOMITING	Yes	No
1: Has the patient been admitted with diarrhoea and/or vomiting? If yes, but non-infectious reason, state reason:		✓
Previous C. diff GDH +ve or toxin +ve? If yes, contact IPCT for advice		✓

If YES →

1. ISOLATE -
   Date:
   Signature:
2. Send stool specimen
   Date:
   Signature:
3. Alert Infection Control Nurse if infectious reason suspected
   Date:
   Signature:
   Commence stool/fluid chart
   Date:
   Signature:

The next question applies only to any patient about to undergo any elective or emergency surgical or endoscopic procedure CJD/vCJD (variant Creutzfeldt Jakob Disease)	Yes	No
Have you ever been notified that you are at an increased risk of CJD or vCJD for public health purposes?		✓

If YES →

Please ask patient to explain further and contact Infection Prevention & Control Team

Date:
Signature:

Infection Prevention and Control document

First MRSA positive result	GDH positive	CPE/VRE first positive	Other multi-drug resistant organism	Other infection risk (please specify)
Date : *Site :*	*Date:* *CDiff toxin positive* *Date:*	*Sample:* ESBL* first positive Date: *Sample:*	*Organism:* First positive: *Date:* *Sample:*	

If isolation required, is the patient isolated? Y (N) NA - If no, please state reason:

* ESBL = E-coli and Klebsiella

THIS DOCUMENT MUST FOLLOW THE PATIENT

Bedrails Assessment

Name : (or attach label)

CHI Number :

INFORMATION: Use Part 1, 2 and 3 below in combination with nursing judgement to inform your decision whether to use or not to use bedrails.

- Patients with capacity can make their own decisions about bedrails
- Patients with visual impairment may be more vulnerable to falling from bed
- Patients with involuntary movements (e.g. spasms) may be more vulnerable to falling from bed and if bedrails are used, may need padded covers.

Complete parts 1, 2 & 3

Part 1 - Assess Mobility & Mental State Factors		Mobility Factors		
		Patient is very immobile (bedfast or hoist dependent)	Patient is neither independent nor immobile	Patient can mobilise without help from staff
Mental State Factors	Patient is confused and disorientated	Use bedrails with care	Bedrails **NOT** recommended	Bedrails **NOT** recommended
	Patient is drowsy	Bedrails recommended	Use bedrails with care	Bedrails **NOT** recommended
	Patient is orientated and alert	Bedrails recommended	Bedrails recommended	Bedrails **NOT** recommended
	Patient is unconscious	Bedrails recommended	N/A	N/A

Part 2 - Assess the Following Additional Patient & Fitting Risks	YES	NO
1. Is the patient confused and mobile enough to attempt to climb over the bedrail?		✓
2. Is the patient small enough to pass between the bed rails? For example, a child or unusually small adult.		✓
3. Are there any gaps that could cause an entrapment risk to the patient's body or head? For example a child or unusually small adult? **Each of the following must be considered to answer Q3 sufficiently.** 1. Entrapment gaps between the bars of the bed rail? 2. Entrapment gaps between bed rail and side of the compressed / overlay mattress? 3. Does the mattress compress easily at the edge to increase the gap between the bed rail and the mattress and is there a potential for entrapment? 4. Entrapment gaps between footboard and end of side rail? 5. Entrapment gaps between headboard and end of side rail? Refer to the Bed Rail Dimension Standards in the Bed Rail Policy if Required		✓
The extra height caused by using an overlay mattress **must not** compromise the safety of the bed rail. The recommended height of the top edge of the bed rail above the mattress (without compression) is to be **more than** 22cm / 220mm. **Have you assessed the potential for the person to roll over the bed rail?**		✓

Note 1 : If YES is answered to ANY (excluding Question 4) of the above questions then bed rails are NOT APPROPRIATE and alternative methods, which are specified in the Bed Rail Policy, must be considered.
Note 2 : If YES is answered to Question 4 and there is "potential for the person to roll over the bed rail" then risk assess the situation further and take action. For example, consider alternatives, increase the level of monitoring, ensure staff are informed at Safety Briefing Handovers, etc.

INFORMATION: The assessment must be reviewed / reassessed if:
1. Medical or mental state changes e.g. patient becomes confused / disorientated / agitated / drowsy or unconscious
2. Changes are made to bed, mattress or type of bedrails.
3. The bedrail has been moved out of position.

Part 3 - Outcome / Assessment Decision

Date of assessment	Time	Bedrails to be used Yes/No/With care	Comments	Sign	Print name
23/10/17	1810	NO	Alert + orintated	LKeith	L·KEITH

Name : (or attach label) CHI Number :	Moving and Handling Assessment								
Activity	**Level of assistance**		**Method/Equipment** (Make, model and SWL of hoist. Type, size & SWL sling should be recorded where used)	**Level of assistance**		**Method/Equipment** (Make, model and SWL of hoist. Type, size & SWL sling should be recorded where used)	**Level of assistance**		**Method/Equipment** (Make, model and SWL of hoist. Type, size & SWL sling should be recorded where used)
Sit to stand	Independent	✓		Independent			Independent		
	Supervision			Supervision			Supervision		
	Assisted - No. of staff			Assisted - No. of staff			Assisted - No. of staff		
	N/A			N/A			N/A		
Standing Transfer	Independent	✓		Independent			Independent		
	Supervision			Supervision			Supervision		
	Assisted - No. of staff			Assisted - No. of staff			Assisted - No. of staff		
	N/A			N/A			N/A		
Lateral Transfer	Independent	✓		Independent			Independent		
	Supervision			Supervision			Supervision		
	Assisted - No. of staff			Assisted - No. of staff			Assisted - No. of staff		
	N/A			N/A			N/A		
Sit up over edge of bed	Independent	✓		Independent			Independent		
	Supervision			Supervision			Supervision		
	Assisted - No. of staff			Assisted - No. of staff			Assisted - No. of staff		
	N/A			N/A			N/A		
Reposition in bed	Independent	✓		Independent			Independent		
	Supervision			Supervision			Supervision		
	Assisted - No. of staff			Assisted - No. of staff			Assisted - No. of staff		
	N/A			N/A			N/A		
Mobility/Walking	Independent	✓		Independent			Independent		
	Supervision			Supervision			Supervision		
	Assisted - No. of staff			Assisted - No. of staff			Assisted - No. of staff		
	N/A			N/A			N/A		
Other (specify)	Independent			Independent			Independent		
	Supervision			Supervision			Supervision		
	Assisted - No. of staff			Assisted - No. of staff			Assisted - No. of staff		
Comments e.g. persons condition, understanding, attachments, further detail of equipment or special considerations									
Version 2 - July 2016	**Date:** **Assessor:**			**Date:** **Assessor:**			**Date:** **Assessor:**		

THIS DOCUMENT MUST FOLLOW THE PATIENT

Name : (or attach label)

CHI Number :

Adapted Waterlow Pressure Area Risk Assessment Chart
Undertake and document risk assessment within 6 hours of admission / transfer to your ward / department
More than one score / category can be used

Reassess if there is a change in individual's condition and repeat regularly according to local protocol

SEX								
Male	1		1	1	1			
Female	2	2						
AGE								
14-49	1		1	1	1			
50-64	2							
65-74	3							
75-80	4							
81+	5	5						
BUILD/WEIGHT FOR HEIGHT *(BMI = Weight in kg/Height in m²)*								
Average - BMI 20 - 24.9	0		0	0				
Above Average - BMI 25 - 29.9	1							
Obese - BMI >30	2							
Below Average - BMI < 20	3	3						
CONTINENCE								
Complete/Catheterised	0		0	0				
Incontinent Urine	1	1						
Incontinent Faeces / catheterised	2							
Doubly Incontinent (urine & faeces)	3							
SKIN TYPE - VISUAL RISK AREAS								
Healthy	0		0	0				
Tissue Paper (thin/fragile)	1	1						
Dry (appears flaky)	1	1						
Oedematous (puffy)	1							
Clammy (moist to touch), pyrexia	1							
Discoloured (bruising / mottled)	2	2						
Broken (established pressure ulcer)	3							
MOBILITY								
Fully Mobile	0		0	0				
Restless / fidgety	1							
Apathetic (sedated/depressed/reluctant to move)	2							
Restricted (restricted by severe pain or disease)	3							
Bedbound (unconscious/unable to change position / traction)	4							
Chairbound (unable to leave chair without assistance)	5	5						
APPETITE								
Average	0		0	0				
Poor	1							
NG Tube / fluids only	2							
NBM / Anorexia	3							
SPECIAL RISKS - TISSUE MALNUTRITION								
Multiple organ failure / terminal cachexia	8		0	0				
Single organ failure eg. Cardiac, Renal, Respiratory	5							
Peripheral Vascular Disease	5							
Anaemia = Hb<8	2							
Smoking	1							
SPECIAL RISKS - NEUROLOGICAL DEFICIT								
Diabetes / MS / CVA / Motor / Sensory / Paraplegia Max 6	4-6	4	0	0				
SPECIAL RISKS - SURGERY / TRAUMA								
On table > 6 hours	8							
On table > 2 hours (up to 48 hrs Post op)	5							
Orthopaedic / below waist / spinal (up to 48hrs. Post op)	5	5						
SPECIAL RISKS - MEDICATION								
Cytotoxic / anti-inflammatory / long term, high dose steroid ***Max 4***	4							
TOTAL SCORE		29	2	2	2			
DATE		09/09	23/10	24/10	25/10			
INITIALS		PC	LL	LS	KB			
TIME		09.00	1810	1005	0950			

<9 = LOW RISK

10-14 = AT RISK

15 + = HIGH RISK

THIS DOCUMENT MUST FOLLOW THE PATIENT

Name : (or attach label) CHI Number :	**Pressure Ulcer Prevention and Care Pathway** **Follow plans 1, 2 or 3 below and complete and evaluate on the Care Planning sheet - please use your CLINICAL JUDGEMENT as well as the Assessment Tools for each individual patient**

Plan 1: Score 9 or less - Daily review of Waterlow assessment
Plan 2: Score 10-14 - Daily review of Waterlow assessment + Person-Centred Care Plan (PCCP) (SSKIN bundle can be utilised with a borderline score)
Plan 3: Score 15+ - Daily review of Waterlow assessment + PCCP + SSKIN bundle
Refer to mattress/cushion guide for appropriate equipment provision
DATIX to be completed for all new or deteriorating pressure damage

Foot Assessment for neuropathy - Check, Protect, Refer			
Does individual have diabetes? **Yes / (No)**		Is neuropathy present? **Yes (No)** (the inability to feel a touch on 2 or more toes = neuropathy)	
If Yes, detail actions to protect feet in care plan			
Check the skin on the feet is intact. If No, detail actions in care plan	**Yes / No**	Current ulcer and/or high risk of developing an ulcer or previous amputation - consult podiatrist	**Yes / No**
Ensure feet are protected. Detail actions in care plan. Include on ward safety brief			
Initials of nurse undertaking assessment:		Date & Time:	

Name : (or attach label)

CHI Number :

MUST Screening Document

Using the : Malnutrition Universal Screening Tool

Height (m)..... Please circle : Actual / Estimate Please circle : Ulna Length / Knee Length	Date referred to dietitian if required:	Admission Weight: Actual/Estimated	Scales used

Date e.g. ...../...../..... and Time	Weight (kg) OR MUAC (Mid Upper Arm Circumference) (cm) Enter A if actual or E if estimated		Step 1 BMI (kg/m²) >20 = 0, 18.5 to 20 = 1, <18.5 = 2		Step 2 % Weight Loss (unplanned) <5% = 0, 5 to 10% = 1, >10% = 2		Step 3 If patient is acutely ill AND there has been, or is likely to be, no nutritional intake for >5 days	Step 4 MUST Score Add Steps 1, 2 & 3 together to give total score	Step 5 ACTION **MUST of 1** = Care Pathway/CNI 1 **MUST of 2** = Care Pathway/CNI 2	Note: If unable to obtain MUST score please record using your professional judgement - an estimate of nutritional risk i.e. Low, Medium, High	Initials of Assessor
	KG	CM	BMI	0,1,2	% Loss	0,1,2,	No = 0 Yes = 2				

- **NOTE :** MUST Score of 0 reassess weekly
- If unable to obtain weight, a mid upper arm circumference should be recorded as per MUST, please complete steps 2 and 3 and use clinical judgement to estimate total score
- Is the **first** recorded % weight loss an **Estimate (E) or Actual (A)** - please state in Step 2 above

Version 2 - July 2016

THIS DOCUMENT MUST FOLLOW THE PATIENT

Medical illustration Dec. 2016-00330

Date/Time/ Care Need No	Evaluation / Significant Changes	Signature
23/10/17	Commenced on diazepam scoring + thiamine for withdrawals. Not for cannula insertion as ~~he~~ may leave the ward with it inserted. Spoken with patient about his mental health - very tearful + open to advice + help STORM + crisis nurse referral complete - needs faxed	S/N KKeith
24/10/17	0500 Colin was late to settle appeared restless and agitated further 20mg diazepam given at 0100 and appears to have settled since this. NEWS STABLE.	S/N MacKay
0910	Scores for 15mg diazepam this a.m mood appears low this morning. Little interaction with staff - STORM / crisis nurse referal faxed to CPN.	S/N K. MacKay
1130	Contacted by Crisis nurse Claire - she feels that Colin is more of a patient for the drug and alcohol team not CPN - she advised he complete CADDS form and fax it to her and she will send it to appropriate person to see if they can assist. Also spoke about housing situation, Claire will look into this but says it is unlikely he will meet criteria for housing locally and that since he is registered with GP in Stirling and has an address there they would be responsible to house him down there - they will get back to us.	S/N K. Mackay
1830	Seen by Gina Johnstone (CADDS) - continues diazepam score chart at present, Colin concerned if he is discharged too soon he will continue to drink. Gina states his notes indicate he has recurring binges of drug / alcohol abuse and normally self detoxes	

Name : (or attach label)

CHI Number :

Care Plan Evaluation

Name : (or attach label) Colin Kerr

CHI Number :

Date / Time / Care Need no:	Evaluation	Signature
cont.	from heroine. Gina is trying to make	
24/10/17	arrangements regarding housing - colin would	
	like to stay in the area meantime while he	
	sorts himself out. Gina will return to ward	
	tomorrow.	S/N K Macky
25/10/17	Colin was late to settle. Diazepam required before going to bed. Had appeared	
05^{00}	to have settled until 03^{30}. Appeared agitated so a further 10mg diazepam	
	given. Observations stable, Colin is having a shower just now. Mood appears low	h.h STN
05^{30}	Colin stated he is feeling nauseated. Cyclizine 50mg oral prescribed and given	h.h STN.
0930	Scores for 5mg diazepam this morning.	
	States he has vomited - nil evidence of same	
	On and off the ward for cigarettes - Awaiting	
	follow up from Gina (CADOS) this morning.	S/N K Mackay
1100	Contacted by Gina she is unable to attend	
	ward. She states colin will not fit criteria	
	to be housed locally and will need to return	
	to Stirling for housing. She states he is	
	known to a support group in Alloa called	
	Signpost. Contacted social work they	
	are unable to provide crisis loan and	
	advise that colin needs to contact the	S/N
	Scottish welfare fund - I will discuss this with colin.	K Macky
1400	Scottish welfare fund will text colin a code to take to	
	paypoint for money for transport - train timetables	
	given. Emergency housing number also given as colin →	

Name : (or attach label)

CHI Number :

Care Plan Evaluation

Date / Time / Care Need no:	Evaluation	Signature
cont.	will be arriving in stirling out of hours.	[illegible]

Name : (or attach label)

CHI Number :

Person-Centred Care Plan

Date	Care Need No.	Clinical Care Need	Individual's Plan of Care	Review/Time Date & signature	Date Discontinued & Signature
23/10		Drug / alcohol abuse - withdrawls.	. Admit Colin to ward. . monitor observations, ECG + obs . repeat NEWS as indicates . Administer medications as per Kardex . commence anto appropriate withdrawl medications - pabrinex and diazepam scoring. . Involve appropriate MDT into Colins care + ensure he also makes choices. . Ensure Colin is comfortable . STORM assessment . crisis nurse referral. . CPN involvement.		
		Individual Goals stability, + to feel better.			

Plan of Care Discussion and Evaluation with individual/family :

Nurse/AHP Signature : lKeith

Date : 23/10.

BEDSIDE DOCUMENTATION

Version 5 – 24.05.17

R773621

KERR
COLIN

29/11/1979
MALE

2911796454

1☑ NEWS CHART
☐ SEPSIS BUNDLE
☐ PAIN ASSESSMENT TOOL CHART

2☑ DRUG KARDEX
☐ THERAPEUTIC DRUG CHARTS
(eg warfarin, PCA, insulin, epidurals, gentamicin, diazepam, blood transfusion)

3☑ MANDATORY RISK ASSESSMENT BOOKLET
(includes infection risk assessment, bedrails, moving and handling, waterlow, foot assessment, MUST)

4☐ FRAILTY SCREENING
☐ FALLS SCREENING, FALLS BUNDLE, POST FALLS BUNDLE
☐ WANDERING PATIENT RISK ASSESSMENT
☐ MDT RISK ASSESSMENT

5☐ DELIRIUM/TIME BUNDLE
☑ 4AT
☐ MINI MENTAL STATE EXAM
☐ MDT VIOLENCE & AGGRESSION RISK ASSESSMENT

6☐ PVC INSERTION & MAINTENANCE BUNDLE
☐ CVC/PICC INSERTION & MATINENANCE BUNDLE

7☐ CONTINENCE ASSESSMENT
☐ CAUTI INSERTION & MAINTENANCE BUNDLE
☐ STOOL CHART

8☐ EATING & DRINKING ASSESSMENT ☐ NIL BY MOUTH ☐FLUID/FOOD BALANCE CHART ☐FLUID, PUMP CHECK CHART ☐ SUPPLEMENTS PRESCRIPTION CHART ☐BM CHART ☐ORAL HEALTH ASSESSMENT ☐ENTERAL FEEDING PRESCRIPTION

9☐ SSKIN BUNDLE
☐ CARE AND COMFORT ROUNDING
☐ BARIATRIC ASSESSMENT
☐ VTE RISK ASSESSMENT

10☐ GETTING TO KNOW ME

DOCUMENTATION MAIN FILE

Version 5 – 24.05.17

1□ DNACPR
(If Applicable)
Refer to medical notes/nursing notes
(delete as appropriate)

2□ ADULTS WITH INCAPACITY CERTIFICATE
(SECTION 47) (If Applicable)
Refer to medical notes/nursing notes
(delete as appropriate)

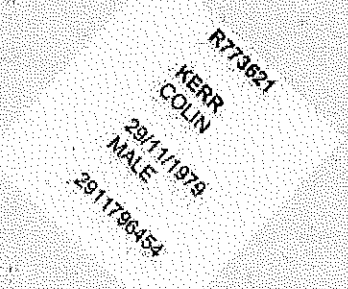
3□ TREATMENT ESCALATION PLAN
(If Applicable)
Refer to medical notes/nursing notes
(delete as appropriate)

4□ ADVANCED DIRECTIVE/ANTICIPATORY CARE PLAN
(If Applicable)
Refer to medical notes/nursing notes
(delete as appropriate)

5□ ACTIVITIES FOR DAILY LIVING ASSESSMENT AND CARE PLANS
Short Stay less than 72 hours of full assessment
(includes patient details, MDT signatures, activities of living assessment, assessment summary, Datix record, record of re-assessments, family and carer dialogue, key changes sheet, SBAR transfer)

6 □ DISCHARGE PLANNING SUMMARY AND CHECKLIST

7□ SBAR & RECORD OF VALUABLES TRANSFER
(If applicable)



10□ ANY OTHER DOCMENTATION

CHI: 2911796454
KERR
COLIN
M 29/11/1979 R773621
20 BRACKEN LANE
STIRLING
FK9 5AB

Named Nurse

SBAR Communication to Rosebank Wing & Handover

S	Name Colin Kerr		Age 37	Consultant Ahmed	
	Presenting Complaint Alcohol + drug withdrawals. suicidal thoughts				
B	Relevant PMH suicide attempt, drug abuse.				
	Social History working in mackays hotel + sacked ?homeless (social issues)				Getting to know me YES ☐ N/A ☑ Given to Family ☐
	DOA 23/10/17	Allergies N/K ☑		MRSA Screen Done ☐ Not Req ☑	CPR Status for
A	Date/ Time	23/10/17	24/10/17 WR Ahmed	25/10/17 WR Ahmed	25/10/17 1030
	Current Investigations	obs ECG Sar ☐ weight ☐	- medically fit for discharge		Colin does not meet the criteria for housing in Caithness
		Dependency Score / 4AT: 0	Dependency Score / 4AT	Dependency Score / 4AT	Dependency Score / 4AT
		Obs/NEWS / Waterlow	Obs/NEWS / Waterlow	Obs/NEWS / Waterlow	Obs/NEWS / Waterlow
	Relevant Current Treatments Referrals	Diazepam scoring thiamine (Not for cannula at present)	- for CPN review ?methadone programme - D/W social work	- try to wean diazepam.	Known to a group called signpost in Alloa
R	Preparation for investigations Transfer/Ward Allocation Bloods to be done Other	storm assessment ☑ crisis nurse ☑ 6.	- CADD's form faxed - Claire (CPN) will discuss with CADDS - edd 25/10/17	- await review / feed back from CADD's team today	Crisis loan will be required for Colin to return to Stirling Social work ☑ Scottish welfare fund 0800083 1887
	Signature	S/N l Keith	S/N kj mackay	S/N kj mackay	Kirsty Bain s/n

Leanne Bremner
609546 - Travel grant

R773621

KERR
COLIN

29/11/1979
MALE

2911796454

The 4A Test: screening instrument for cognitive impairment and delirium

Admission

Date: Time:

Tester:	Kerr			
Date:	23/10			
Time:	18:10			

[1] ALERTNESS

This includes patients who may be markedly drowsy (eg. difficult to rouse and/or obviously sleepy during assessment) or agitated/ hyperactive. Observe the patient. If asleep, attempt to wake with speech or gentle touch on shoulder. Ask the patient to state their name and address to assist rating.

Normal (fully alert, but not agitated, throughout assessment)	(0)	0	0	0
Mild sleepiness for <10 seconds after waking, then normal	0	0	0	0
Clearly abnormal	4	4	4	4

[2] AMT4

Age, date of birth, place (name of the hospital or building), current year.

No mistakes	(0)	0	0	0
1 mistake	1	1	1	1
2 or more mistakes/untestable	2	2	2	2

[3] ATTENTION

Ask the patient: "Please tell me the months of the year in backwards order, starting at December." To assist initial understanding one prompt of "what is the month before December?" is permitted.

Months of the year backwards

Achieves 7 months or more correctly	(0)	0	0	0
Starts but scores < 7 months / refuses to start	1	1	1	1
Untestable (cannot start because unwell, drowsy, inattentive)	2	2	2	2

[4] ACUTE CHANGE OR FLUCTUATING COURSE

Evidence of significant change or fluctuation in: alertness, cognition, other mental function (eg. paranoia, hallucinations) arising over the last 2 weeks and still evident in last 24hrs

No	(0)	0	0	0
Yes	4	4	4	4

4AT SCORE

4 or above: possible delirium +/- cognitive impairment
1-3: possible cognitive impairment
0: delirium or cognitive impairment unlikely
(but delirium still possible if [4] information incomplete)

0

ABBREVIATIONS

COPD	Chronic Obstructive Pulmonary Disease	CTPA	CT Pulmonary Angiograph
NIDDM	Non Insulin Dependent Diabetes Mellitus	CTKUB	CT Kidney Ureter Bladder
IDDM	Insulin Dependent Diabetes Mellitus	CXR	Chest X-Ray
CKD	Chronic Kidney Disease	AXR	Abdominal X-Ray
CA	Cancer	US	Ultrasound
PE	Pulmonary Embolism	MSSU	Mid Stream Sample of Urine
DVT	Deep Vein Thrombosis	CSU	Catheter Specimen of Urine
TIA	Transient Ischaemic Attack	SOU	Sample Of Urine
AF	Atrial Fibrillation	LP	Lumbar Puncture
HF	Heart Failure	SFC	Stool For Culture
IHD	Ischaemic Heart Disease	FR	Fluid Restriction
MND	Motor Neuron Disease	I/O	Input/Output
MI	Myocardial Infarction	IVABX	Intravenous Antibiotic
NSTEMI	Non ST-segment Elevation Myocardial Infarction	OABX	Oral Antibiotics
LRTI	Lower Respiratory Tract Infection	IVF	Intravenous Fluids
CABG	Coronary Artery Bypass Graft	ACS	Acute Coronary Syndrome
CVA	Cerebral Vascular Accident		
OD	Overdose		
LOC	Loss of Consciousness		
NOF	Neck of Femur		
#	Fracture		
SOB	Shortness Of Breath		

R773621

KERR
COLIN

29/11/1979
MALE

2911796454

DNR	Do Not Resuscitate	PT	Physiotherapist
OA	On Admission	SSA	Single Shared Assessment
EDD	Estimated Discharge Date	NOK	Next Of Kin
WR	Ward Round		
W/L	Waiting List		
CPN	Community Psychiatric Nurse		
SW	Social Work		

Patient lal

mptom trigger scoring sheet for use in alcohol withdrawal only)

Prescriber's signature: [signature]
PRINT NAME: WMBREW
Date: 23-10-17 Ward: Rosebank
Consultant: AHMED

** Please ensure Pabrinex and thiamine are prescribed in accordance with the vitamin supplementation guidelines**

Date	23/10/1X							24/10							25/10						
Time	06:00	13:00	18:00	22:00				08:00	13:00	18:00	22:00	330	180		08:00	13:00	18:00	22:00	0330		
Pulse				1				1	1	1	1	1	1		1	1			1		
Tremor				2				2	1	1	1	1	1		1	1			1		
Perspiration				2				2	1	1	2	2	1		1	1			1		
Anxiety				3				2	1	1	2	2	2		1	1			2		
Agitation				3				1	0	0	0	2	1		1	1			2		
Perceptual disturbance				1				0	0	0	0	0	1						0		
Orientation				0				0	0	0	0	0	0						0		
Score				12				8	4	4	6	8	7		5	5			7		
Dose				10				15mg	5mg	5mg	10mg	15mg	10mg		5mg	5mg			10mg		
Initial				[illegible]				[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]			[illegible]		

Date																				
Time	06:00	13:00	18:00	22:00				06:00	13:00	18:00	22:00				06:00	13:00	18:30	22:00		
Pulse																				
Tremor																				
Perspiration																				
Anxiety																				
Agitation																				
Perceptual disturbance																				
Orientation																				
Score																				
Dose																				
Initial																				

Date															
Time	06:00	13:00	18:00	22:00	06:00	13:00	18:00	22:00	06:00	13:00	18:00	22:00	06:00	13:00	18:00	22:00
Pulse																
Tremor																
Perspiration																
Anxiety																
Agitation																
Perceptual disturbance																
Orientation																
Score																
Dose																
Initial																

Diazepam: recommended maximum dose in 24 hours = 120mg. Consult prescriber before exceeding this dose.

See also Highland Formulary section 4.10 'Alcohol dependence' and vitamin supplementation guidelines at the end of Chapter 9.

Score	Diazepam dose
0 – 1	no dose
2 – 3	2 mg
4 – 5	5 mg
6 – 7	10 mg
8 – 10	15 mg
Over 10	20 mg

	SCORE
PULSE	
79 or below	0
80-99	1
100-119	2
120 or over	3
TREMOR	
No tremor	0
Tremor of outstretched arms	1
Constant tremor of arms	2
Whole body tremor	3
PERSPIRATION	
None	0
Moist skin	1
Beads of sweat	2
Profuse sweating	3
ANXIETY	
None	0
Understandable anxiety	1
Anxiety & panics	2
Constant panic-like anxiety	3
AGITATION	
None	0
Restlessness	1
Can't remain seated	2
Constantly restless	3
PERCEPTUAL DISTURBANCE	
None	0
Illusion or fleeting hallucinations	1
Formed hallucinations	2
Vivid hallucinations	3
ORIENTATION	
Correct	0
Uncertain of date	1
Wrong date >2 days	2
Time & place wrong	3

Approximate equivalent doses:
Diazepam 5mg ≡ Chlordiazepoxide 15mg

Lead reviewer: Substance Misuse Review Group
Date: June 2016
Version: 7

Approved by: Formulary Subgroup of NHS Highland ADTC
Review date: June 2018
Warning: Document uncontrolled when printed

Ensure Pabrinex and thiamine are prescribed in accordance with the vitamin supplementation guidelines.

GUIDELINES FOR THE USE OF DIAZEPAM SCORING SHEET

1. Before using the scoring sheet, ensure that prescriber has signed both this scoring sheet and the Drug *Kardex* and that diazepam is prescribed as '2 to 20mg as per scoring sheet'.
2. Explain how the form is used to the client.
3. Take the client's pulse and write the score in the appropriate column on the sheet in accordance with the time of administration, eg 08:00.
4. Observe the client to see if any tremor is evident; if necessary, ask them to hold out their hand. Tremor can be observed if the client takes a drink of water with other medication. Place score in appropriate column.
5. Score the perspiration by feeling the client's open palms when taking their pulse or through observation. Note in the appropriate column.
6. Score anxiety by asking the client an open question, eg "How are you feeling?" If necessary take the client aside to ask the question or to explore further. In this instance 'panic' is taken to refer to clients who are experiencing anxiety attacks. Score in appropriate column.
7. Agitation can be assessed on a continual basis. Please score in the column at medication times.
8. The initial appraisal of perceptual disturbance can be done on admission and then on a continuous assessment to be scored at medication times. 'Formed hallucinations' are when the client is able to describe hallucinations and recognise them as such. 'Vivid hallucinations' are when the client is physically acting on them and lacks insight.
9. Initial assessment of orientation should be completed on admission and further evaluation carried out on a continuous basis if necessary and scored at medication times.
10. Add the scores together and write the total score at the bottom of the column. Identify the amount of diazepam to be administered by referring to the scoring table. For example – score 4 – give 5mg diazepam.
11. It is good practice to record the diazepam dose and initial on the Drug *Kardex*. Diazepam can be given outwith medication times if necessary and space is provided on the sheet to accommodate this.
12. Drug *Kardexes* need to be reviewed as appropriate to ensure that the clients do not receive medication for longer than necessary, as they may register a score due to anxiety symptoms rather than withdrawal.
13. If the amounts of medication being given are increasing or remaining static, it may be more appropriate to commence on set reducing doses.
14. If clients have been involved in recent physical exercise, ask them to rest for at least five minutes before scoring.

Medication Prescription Chart (Short Version)

NHS Highland

Nar

Date of Birth : Age:

Hospital Number: CHI :

Date of Admission: Consultant :

Ward : Chart no:.....of.....

Weight: (metric) Height: Surface area:

Additional prescribing Sheets in use (please also document within *Kardex*)

Name	Tick ✔
Warfarin	
Insulin	
Chemotherapy	
Dietary Supplements	
Total Parental Nutrition (TPN)	
Gentamicin	
Diazepam	✔
Heparin Infusion	
Epidural	
Syringe pump prescribing chart	

KNOWN DRUG SENSITIVITIES Circle below

No -nil known ✔ Yes - list below

KNOWN or SUSPECTED ADVERSE REACTION Circle below

No -nil known ✔ Yes - list below

MEDICINE	ADVERSE REACTION

ONCE ONLY AND PRE-MED (*NB Time must be in 24 hour format)

Date	Time*	Drug (Approved Name)	Dose	Route	Prescriber's Signature PRINT NAME	Time Given	Given By	Checked by (if app)
24/10/17	1550	DIAZEPAM	2.5mg	PO	Sig: Print	1555	JS.	
25/10/17	11[N]	BUCCASTEM	3mg	SL	Sig: Print	1110	KJM	
					Sig: Print			
					Sig: Print			
					Sig: Print			
					Sig: Print			
					Sig: Print			
					Sig: Print			
					Sig: Print			
					Sig: Print			
					Sig: Print			
					Sig: Print			
					Sig: Print			
					Sig: Print			

CHI: 2911796454

KERR
COLIN
M 29/11/1979 R773621
20 BRACKEN LANE
STIRLING
FK9 5AB

Date of Birth : Age:

REGULAR THERAPY

Weight if applicable.....(metric)
Height if applicable.....(metric)

*N.B. Time must be in 24 hour format

Drug (Approved Name)		Dose
DIAZEPAM		0-20MG
Route	Indication	Comments
ORAL		
Start Date 23/10/17	Stop date Initial	
Signature VLOSS	Name VLOSS	

Time* \ Date	24/10/17	24/10	25/10
	SEE	SCORING	CHART
08⁰⁰		16	KJN
12⁰⁰		KB	KJN
18⁰⁰		KJN	
22⁰⁰	LC SW	RR	

Drug (Approved Name)		Dose
THIAMINE		50MG
Route	Indication	Comments
ORAL		
Start Date 23/10/17	Stop date Initial	
Signature VLOSS	Name VLOSS	

Time*										
08⁰⁰		16	KJN							
12⁰⁰		KB	KJN							
18⁰⁰		KJN								
22⁰⁰	LC SW	RR								

Drug (Approved Name)		Dose
Route	Indication	Comments
Start Date	Stop date Initial	
Signature	Name	

Drug (Approved Name)		Dose
Route	Indication	Comments
Start Date	Stop date Initial	
Signature	Name	

Drug (Approved Name)		Dose
Route	Indication	Comments
Start Date	Stop date Initial	
Signature	Name	

CODES		
If a dose is not administered as prescribed, initial entry and then enter a code in the column with a circle drawn around the entry according to the reason as follows : (***Medical staff or prescriber contacted if appropriate**)		
1. Patient refuses * 2. Patient not present on ward* 3. Medicine not available * - ORDER FROM PHARMACY (see table) 4. Instructions not clear or legal* - CLARIFY WITH PRESCRIBER 5. Patient self administered medicine - supervised as per Self Admin Policy 6. Nil by mouth* 7. Asleep/drowsy *	8. Unable to swallow* 9. Vomiting/nausea* 10. Time varied on Dr's instructions 11. Once only/as required medication 12. Dose witheld on Dr's instructions 13. No IV access* 14. Medication not required	
To be specified in the Administration Comments section		
15. possible drug reaction/side effect *	16. With held for clinical reasons	17. Other reason

Ordered Drugs (code 3)

Date	Drug	Inits

Date	ADMINISTRATION COMMENTS	Inits

CHI: 2911796454
KERR
COLIN
M 29/11/1979 R773621
20 BRACKEN LANE
STIRLING
FK9 5AB

Date of Birth : Age:

REGULAR THERAPY

Weight if applicable.........................(metric)
Height if applicable.........................(metric)

*N.B. Time must be in 24 hour format

Date / Time									

Drug (Approved Name) | Dose
Route | Indication | Comments
Start Date | Stop date Initial
Signature | Name

Drug (Approved Name) | Dose
Route | Indication | Comments
Start Date | Stop date Initial
Signature | Name

Drug (Approved Name) | Dose
Route | Indication | Comments
Start Date | Stop date Initial
Signature | Name

Drug (Approved Name) | Dose
Route | Indication | Comments
Start Date | Stop date Initial
Signature | Name

Drug (Approved Name) | Dose
Route | Indication | Comments
Start Date | Stop date Initial
Signature | Name

CODES	Ordered Drugs (code 3)		
If a dose is not administered as prescribed, initial entry and then enter a code in the column with a circle drawn around the entry according to the reason as follows : (***Medical staff or prescriber contacted if appropriate**)	Date	Drug	Inits
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To be specified in the Administration Comments section 15. possible drug reaction/side affect * 16. With held for clinical reasons 17. Other reason			

Date	ADMINISTRATION COMMENTS	Inits

Name of Patient:
CHI: 2911796454
KERR
COLIN
M 29/11/1979 R773621
20 BRACKEN LANE
STIRLING
FK9 5AB
H
Cl
Da Age:

REGULAR THERAPY

Weight if applicable.........................(metric)
Height if applicable.........................(metric)

*N.B. Time must be in 24 hour format

Drug (Approved Name)		Dose	Date / Time*									
Route	Indication	Comments										
Start Date	Stop date Initial											
Signature	Name											

Drug (Approved Name)		Dose										
Route	Indication	Comments										
Start Date	Stop date Initial											
Signature	Name											

Drug (Approved Name)		Dose										
Route	Indication	Comments										
Start Date	Stop date Initial											
Signature	Name											

Drug (Approved Name)		Dose										
Route	Indication	Comments										
Start Date	Stop date Initial											
Signature	Name											

Drug (Approved Name)		Dose										
Route	Indication	Comments										
Start Date	Stop date Initial											
Signature	Name											

CODES

If a dose is not administered as prescribed, initial entry and then enter a code in the column with a circle drawn around the entry according to the reason as follows : (***Medical staff or prescriber contacted if appropriate**)

1. Patient refuses *
2. Patient not present on ward*
3. Medicine not available * - ORDER FROM PHARMACY (see table)
4. Instructions not clear or legal* - CLARIFY WITH PRESCRIBER
5. Patient self administered medicine - supervised as per Self Admin Policy
6. Nil by mouth*
7. Asleep/drowsy *
8. Unable to swallow*
9. Vomiting/nausea*
10. Time varied on Dr's instructions
11. Once only/as required medication
12. Dose withheld on Dr's instructions
13. No IV access*
14. Medication not required

To be specified in the Administration Comments section

15. possible drug reaction/side effect * 16. With held for clinical reasons 17. Other reason

Ordered Drugs (code 3)		
Date	Drug	Inits

Date	ADMINISTRATION COMMENTS	Inits

Name [redacted] CHI: 2911796454

KERR
COLIN
M 29/11/1979 R773621
20 BRACKEN LANE
STIRLING
FK9 5AB

Hospital

Date of I

*N.B. Time must be in 24 hour format

SYMPTOMATIC RELIEF POLICY

DRUGS MAY ONLY BE ADMINISTERED FROM THE SYMPTOMATIC RELIEF POLICY IF:

- **PATIENT IS OVER 16 YEARS OLD**
- **SYMPTOMATIC RELIEF HAS BEEN PRESCRIBED**
- **NURSING STAFF INVOLVED IN ADMINISTRATION HAVE COMPLETED THE TRAINING**

Maximum of two consecutive days per drug - otherwise contact prescriber

Medicine	Code	Main Indication	Dose	Route	Maximum per 24 hours per policy
Paracetamol	A	Mild to moderate pain only	Up to 1 gram, at least 4 hours apart	Oral/rectal	2 doses
Senna	B	Constipation	7.5 to 15 mgs	Oral	2 doses
Glycerol Suppositories	C	Constipation	1 to 2 suppositories	Rectal	2 doses
Sodium Citrate Enema	D	Constipation	1 enema	Rectal	1 enema
Oral Rehydration Salts	E	Diarrhoea	1 sachet	Oral	2 doses
Epaderm® Ointment	F	Dry skin emollient	Apply liberally	Topical	2 doses
Diprobase® Cream	G	Dry skin emollient	Apply liberally	Topical	2 doses
Peptac® Liquid	H	Indigestion	10 to 20 mls	Oral	2 doses

SYMPTOMATIC RELIEF POLICY

Exceptions (please circle)

No **Yes** (please list)

Start date | Stop date | Initial

Signature

Name

Comments

Date									
Time*									
Code									
Dose/Route									
Initial									
Date									
Time*									
Code									
Dose/Route									
Initial									

AS REQUIRED THERAPY

Weight if applicable.....(metric) Height if applicable.....(metric)

*NB Time must be in 24 hour format

Drug (Approved Name): DIAZEPAM

Dose: 2 - 20MGS | Route: O | Frequency & comments: SEE SCORING CHART

Start Date: 23/10/17 | Stop date | Initial

Signature: Ross | Name: Ross

Date	24/10	24/10	24/10	24/10	24/10	25/10/17			
Time*	0145	0520	1330	1150	1935	0345			
Dose/Route	20MG O	20/O	PO 15	PO 5	PO 10 mg	PO 10			
Initial	LM	LM	KM	KB	KB	RR			
Date									
Time*									
Dose/Route									
Initial									

Drug (Approved Name): OXAZINE

Dose: 50 mg | Route: PO | Frequency & comments:

Start Date: 25/10 | Stop date | Initial

Signature | Name: EMERGENCY

Date	25/10								
Time*	0545								
Dose/Route	50/O								
Initial	SMP								
Date									
Time*									
Dose/Route									
Initial									

CODES	Ordered Drugs (code 3)		
If a dose is not administered as prescribed, initial entry and then enter a code in the column with a circle drawn around the entry according to the reason as follows : **(*Medical staff or prescriber contacted if appropriate)**	Date	Drug	Inits
1. Patient refuses * 2. Patient not present on ward* 3. Medicine not available * - ORDER FROM PHARMACY (see table) 4. Instructions not clear or legal* - CLARIFY WITH PRESCRIBER 5. Patient self administered medicine - supervised as per Self Admin Policy 6. Nil by mouth* 7. Asleep/drowsy * 8. Unable to swallow* 9. Vomiting/nausea* 10. Time varied on Dr's instructions 11. Once only/as required medication 12. Dose witheld on Dr's instructions 13. No IV access* 14. Medication not required			
To be specified in the Administration Comments section 15. possible drug reaction/side effect * 16. With hold for clinical reasons 17. Other reason			

***NB Time must be in 24 hour format**

Drug (Approved Name)			Date									
			Time*									
Dose	Route	Frequency & comments	Dose/Route									
			Initial									
Start Date	Stop date		Date									
	Initial		Time*									
Signature		Name	Dose/Route									
			Initial									

Drug (Approved Name)			Date									
			Time*									
Dose	Route	Frequency & comments	Dose/Route									
			Initial									
Start Date	Stop date		Date									
	Initial		Time*									
Signature		Name	Dose/Route									
			Initial									

Drug (Approved Name)			Date									
			Time*									
Dose	Route	Frequency & comments	Dose/Route									
			Initial									
Start Date	Stop date		Date									
	Initial		Time*									
Signature		Name	Dose/Route									
			Initial									

Drug (Approved Name)			Date									
			Time*									
Dose	Route	Frequency & comments	Dose/Route									
			Initial									
Start Date	Stop date		Date									
	Initial		Time*									
Signature		Name	Dose/Route									
			Initial									

Drug (Approved Name)			Date									
			Time*									
Dose	Route	Frequency & comments	Dose/Route									
			Initial									
Start Date	Stop date		Date									
	Initial		Time*									
Signature		Name	Dose/Route									
			Initial									

CHI: 2911796454
KERR
COLIN
M 29/11/1979 R773621
20 BRACKEN LANE
STIRLING
FK9 5AB

Date of Birth: Age:

AS REQUIRED THERAPY

Weight if applicable........................(metric)
Height if applicable........................(metric)

***NB Time must be in 24 hour format**

Drug (Approved Name)			Date									
			Time*									
Dose	Route	Frequency & comments	Dose/Route									
			Initial									
Start Date	Stop date		Date									
	Initial		Time*									
Signature		Name	Dose/Route									
			Initial									

Drug (Approved Name)			Date									
			Time*									
Dose	Route	Frequency & comments	Dose/Route									
			Initial									
Start Date	Stop date		Date									
	Initial		Time*									
Signature		Name	Dose/Route									
			Initial									

Drug (Approved Name)			Date									
			Time*									
Dose	Route	Frequency & comments	Dose/Route									
			Initial									
Start Date	Stop date		Date									
	Initial		Time*									
Signature		Name	Dose/Route									
			Initial									

Drug (Approved Name)			Date									
			Time*									
Dose	Route	Frequency & comments	Dose/Route									
			Initial									
Start Date	Stop date		Date									
	Initial		Time*									
Signature		Name	Dose/Route									
			Initial									

Drug (Approved Name)			Date									
			Time*									
Dose	Route	Frequency & comments	Dose/Route									
			Initial									
Start Date	Stop date		Date									
	Initial		Time*									
Signature		Name	Dose/Route									
			Initial									

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If a dose is not administered as prescribed, initial entry and then enter a code in the column with a circle drawn around the entry according to the reason as follows : **(*Medical staff or prescriber contacted if appropriate)**	Date	Drug	Inits
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To be specified in the Administration Comments section 15. possible drug reaction/side effect * 16. With held for clinical reasons 17. Other reason			

***NB Time must be in 24 hour format**

Drug (Approved Name)			Date									
			Time*									
Dose	Route	Frequency & comments	Dose/Route									
			Initial									
Start Date	Stop date		Date									
	Initial		Time*									
Signature		Name	Dose/Route									
			Initial									

Drug (Approved Name)			Date									
			Time*									
Dose	Route	Frequency & comments	Dose/Route									
			Initial									
Start Date	Stop date		Date									
	Initial		Time*									
Signature		Name	Dose/Route									
			Initial									

Drug (Approved Name)			Date									
			Time*									
Dose	Route	Frequency & comments	Dose/Route									
			Initial									
Start Date	Stop date		Date									
	Initial		Time*									
Signature		Name	Dose/Route									
			Initial									

Drug (Approved Name)			Date									
			Time*									
Dose	Route	Frequency & comments	Dose/Route									
			Initial									
Start Date	Stop date		Date									
	Initial		Time*									
Signature		Name	Dose/Route									
			Initial									

Drug (Approved Name)			Date									
			Time*									
Dose	Route	Frequency & comments	Dose/Route									
			Initial									
Start Date	Stop date		Date									
	Initial		Time*									
Signature		Name	Dose/Route									
			Initial									

Good Prescription Writing Guidelines

1. Highland Joint Formulary (HJF)	• Please use/refer to the Highland Joint Formulary when choosing appropriate prescription. • Prescribers must be aware of the FORMULARY and LICENSE STATUS of any medicine prescribed and must comply with all policies relating to the supply of non-formulary medicines, refer to Formulary website on NHS Highland intranet.
2. Write legibly	Prescriptions should be : • In ink (or otherwise so as to be indelible) • dated • include the full name and address of the patient, and • signed in BLACK ink by the prescriber.
3. Age, Date of Birth and CHI Number	• These should always be stated. In the case of prescription-only medicines, it is a legal requirement to state the age for children under 12 years of age.
4. Dose	• Where possible, the dose must be stated in the International System of Units (SI Units). • Abbreviations for grams (g) ; milligrams (mg), millilitres (mL) and litres (L) may be used. • Micrograms, nanograms and units must be written in full. • The dosage from, dose, route, timing and frequency should be stated.
5. Frequencies and Routes of Administration	• These should be written in FULL.
6. Decimal Points	• AVOID unnecessary zeros and naked decimal points. • Decimal points should always have a number covering in front e.g. 0.5 mg and NOT .5 mg. • Decimal points should be clearly prominent and ideally, centred. • WHOLE numbers should be kept whole e.g. 5mg and not 5.0mg. • Quantities of 1 gram or more should be written as gram/grams. • Quantities less than 1 gram should be written as milligrams e.g. 500 mg. • Quantities less than 1 mg should be written in micrograms e.g. 100 micrograms, not 0.1mg.
7. As directed	AVOID writing 'as directed'.
8. Non-proprietary (Generic) Names	Recommended International Non-proprietary Names (ie generic names as they appear in the British National Formulary) should be used for a medicine and be written in full except for some combination preparations and some modified release preparations.
9. Abbreviations	Abbreviations should be avoided.
10. Weight or surface area	Where the weight or surface area is required to calculate a dose, write this on the prescription.
11. Administration	A medicine that is NOT CORRECTLY PRESCRIBED must not be administered if it is considered that following the prescribing instruction may be harmful to the patient.
12. Drug kardex	The drug *Kardex* MUST include the patient's • name • hospital number (or CHI number) • date of birth, and • weight and/or surface area (where dosage requires it).
13. Prescribers	Medicines must be prescribed on the appropriate PRESCRIPTION SHEET by a registered or provisionally registered medical practitioner, dentist, extended independent or supplementary prescriber.
14. Kardex prescriptions	• These must be DATED and WRITTEN LEGIBLY, TYPED or ELECTRONICALLY produced in indelible ink specifying the DOSAGE FORM, DOSE, ROUTE, TIMING and FREQUENCY with the prescriber's SIGNATURE and printed name for each item prescribed, • CARE must be taken to ensure correct section of form is used e.g. ONCE ONLY and PRE-MED REGULAR THERAPY or AS REQUIRED THERAPY.
15. Capitals	All written prescribing information on the Drug *Kardex* must be in capitals.
16. As required medicines	• For medicines prescribed on an 'as required' basis, abbreviations must NOT be used and DOSE, DOSAGE INTERVAL and INDICATION for the medicine should be clearly stated e.g. 500 mg every four hours for a headache when required. • MAXIMUM DOSE should be indicated, if appropriate.
17. Discontinuation	• To discontinue a medicine, the prescriber must draw a DIAGONAL LINE through the complete entry, enter the date in the 'stop date' box and initial it. • When an amendment to a prescription is needed, the item to be changed must be discontinued in the same way.
18. Prescription Sheets	• Not more than one prescription sheet should be used for each patient. Old prescription sheets should be cancelled by drawing TWO PARALLEL DIAGONAL LINES across them and writing CANCELLED. It should be authorised by the prescriber's SIGNATURE and DATE OF CANCELLATION. • A NEW SHEET should be used for each hospital admission.
19. Rewriting	If it is necessary to rewrite a prescription from the ORIGINAL START DATE for each item must be used.
20. Special Sheets	When special sheets (e.g. oral anticoagulants, insulin and continuous infusions) are in use, items must also be prescribed on the Drug *Kardex* with the dose stated AS CHARTED.
21. Allergy section	• An entry MUST be made in the Allergy/Drug sensitivity section. • Write either DRUG NAME or NIL KNOWN.

CHI: 2911796454

KERR
COLIN
M 29/11/1979 R773621

20 BRACKEN LANE
STIRLING
FK9 5AB

Observation Chart for the Iational Early Warning Score (NEWS)

NHS Highland

Admission Date 23.6.17 Ward/Dept.: ED RBWH

DATE	23.6.17	23.6.17	23.6.17	24/6				
TIME	1500	1524	2245	02	10	22[00]	0950	
RESP. RATE ≥25								3
RESP. RATE 21-24								2
RESP. RATE 12-20		15	16	16	18	16	16	
RESP. RATE 9-11								1
RESP. RATE ≤8								3
SpO2 ≥96		96	96	97	97	100	97	
SpO2 94-95								1
SpO2 92-93								2
SpO2 ≤91								3
Inspired O2 %								2
TEMP ≥39°								2
TEMP 38°								1
TEMP 37°		37.1	37.4		37.2	36.7	36.4	
TEMP 36°								
TEMP ≤35°			34.4					3
NEWS SCORE uses Systolic BP 230								3
220								
210								
200								
190								
180								
170								
160								
150								
BLOOD PRESSURE 140		131				135		
BLOOD PRESSURE 130								
BLOOD PRESSURE 120			127				120	
BLOOD PRESSURE 110					110			111
BLOOD PRESSURE 100								
BLOOD PRESSURE 90		85	96		82	80	89	85
BLOOD PRESSURE 80								
BLOOD PRESSURE 70								3
BLOOD PRESSURE 60								
BLOOD PRESSURE 50								
HEART RATE >140								3
HEART RATE 130								
HEART RATE 120								2
HEART RATE 110								
HEART RATE 100								1
HEART RATE 90		88	99		62	98	97	
HEART RATE 80								86
HEART RATE 70								
HEART RATE 60								
HEART RATE 50								
HEART RATE 40								1
HEART RATE 30								3
Level of consciousness	Alert	✓	✓	✓	✓	✓	✓	
Level of consciousness	V/P/U							3
SCORE		0	4	0	1	1	0	SCORE
Monitoring Freq.								
Escal Plan Y/N n/a								
Initials		[illegible]						

If observations are expected for patient's clinical condition, please note expected parameters below

	Heart rate	RR	SpO2	BP	Temp.
acceptable parameters					

Doctor's signature:

Date & Time:

BLOOD SUGAR																								
Nausea																								
Pain score																								
Sedation																								
Urine Output																								
Bowels																								

Signs of Systemic Inflammation Criteria

Date							
Time							
Respiratory rate >20							
Temperature <36 or >38							
Heart rate >90							
White cell count <4 or >12							
Acutely altered mental state (4AT ≥4 or <A on AVPU)							
Bedside Glucose >7.7 mmol/L without diabetes							
Total							

If SSI 2 or more **AND** infection suspected
THIS IS SEPSIS
Commence the sepsis six immediately and make a rapid assessment for the presence of **ANY** organ dysfunction
Seconds Count!

Sepsis Six: Aim to complete within 1 hour of arrival in hospital (OR for inpatients: within 1 hour since SSI criteria reached)

Time : Initials : Notes/Result:

1. Oxygen to achieve Saturations >94%≤ 98% (88-92 in severe COPD) ☐ ....
2. IV fluids (≥500ml/hr OR 20ml/kg stat if organ dysfunction) ☐ ....
3. Blood cultures ☐ ....
4. Intravenous antibiotics as per local guidelines ☐ ....
5. Measure lactate and FBC Lactate ☐ FBC ☐ ....
6. Catheterise if organ dysfunction apparent ☐ ....

Look for signs of organ dysfunction (laboratory tests should be requested as emergencies, and results must be available and acted upon within 1 hour)

Delirium Screening 4AT

Date:							
Time:							
Circle score							
(1) ALERTNESS							
Normal (fully alert but not agitated, throughout assessment)	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Mild sleepiness for <10 seconds after waking, then normal	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Clearly abnormal	**4**	**4**	**4**	**4**	**4**	**4**	**4**
(2) 4AT							
Age, date of birth, place (name of the hospital or building),current year.							
No mistakes	**0**	**0**	**0**	**0**	**0**	**0**	**0**
1 mistake	**1**	**1**	**1**	**1**	**1**	**1**	**1**
2 or more mistakes/untestable	**2**	**2**	**2**	**2**	**2**	**2**	**2**
(3) ATTENTION							
Ask the patient : "Please tell me the months of the year in backwards order, starting at December." To assist initial understanding one prompt of "what is the month before December?" is permitted.							
Months of the year backwards. Achieves 7 months or more correctly	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Starts but scores <7 months / refuses to start	**1**	**1**	**1**	**1**	**1**	**1**	**1**
Untestable (cannot start because unwell, drowsy, inattentive)	**2**	**2**	**2**	**2**	**2**	**2**	**2**
(4) ACUTE CHANGE OR FLUCTUATING COURSE							
Evidence of significant change or fluctuation in:alertness,cognition, other mental function (eg. paranoia, hallucinations) arising over the last 2 weeks and still evident in last 24 hrs							
No	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Yes	**4**	**4**	**4**	**4**	**4**	**4**	**4**
4 or above : possible delirium +/- cognitive impairment **4AT Score Total**							
1-3 : possible cognitive impairment							
0 : delirium or cognitive impairment unlikely (but delirium still possible if [4] information incomplete)							

Waterlow Pressure Score Prevention/Treatment Policy

Circle scores in table, add total. Several scores per category can be used.

If you are completing Waterlow in Nursing Assessment Bundle do not complete here

Build/Weight for Height	A	B	C	D
Average-BMI 18.5-24.9	0	0	0	0
Above average-BMI 25 - 29.9	1	1	1	1
Obese - BMI >30	2	2	2	2
Below Average BMI-<18.5	3	3	3	3
Skin Type-Visual Risk Areas	✱	✱	✱	✱
Healthy	0	0	0	0
Tissue paper (thin/fragile)	1	1	1	1
Dry (appears flaky)	1	1	1	1
Oedematous (puffy)	1	1	1	1
Clammy (moist to touch)	1	1	1	1
pyrexia				
Discoloured (bruising/mottled)	2	2	2	2
Broken (established ulcer)	3	3	3	3
Nutritional Element	✱	✱	✱	✱
Unplanned weight loss in past 3-6 months				
<5%, BMI>20	0	0	0	0
5-10%, BMI 18.5-20	1	1	1	1
BMI <18.5	2	2	2	2
Patient/client acutely ill or not nutritional intake > 5 days	3	3	3	3

Continence	A	B	C	D
Complete/Catheterised	0	0	0	0
Incontinent urine	1	1	1	1
Incontinent faeces / Catheterised	2	2	2	2
Doubly Incontinent (urine & faeces)	3	3	3	3
Special Risks				
Tissue Malnutrition	✱	✱	✱	✱
Multiple organ failure Terminal Cachexia	8	8	8	8
Single organ failure eg Cardiac, Renal, Respiratory	5	5	5	5
Peripheral Vascular Disease	5	5	5	5
Anaemia	2	2	2	2
Smoking	1	1	1	1
Medication	✱	✱	✱	✱
Cytotoxic/Anti-inflamm /longterm, high dose steroid ***Max 4***	4	4	4	4

Mobility	A	B	C	D
Fully mobile	0	0	0	0
Restless/Fidgety	1	1	1	1
Apathetic (sedated/ depressed/reluctant to move)	2	2	2	2
Restricted (restricted by severe pain or disease)	3	3	3	3
Bedbound	4	4	4	4
Chairbound	5	5	5	5
Surgery/Trauma	✱	✱	✱	✱
On table > 6 hours	8	8	8	8
Orthopaedic/below waist/spinal (up to 48 hrs Post op)	5	5	5	5
On table > 2 hours (up to 48 hrs Post op)	5	5	5	5
Neurological Defict	✱	✱	✱	✱
Diabetes/ MS/ CVA/ Motor/ Sensory/ Paraplegia	4-6	4-6	4-6	4-6

Sex Age	A	B	C	D
Male	1	1	1	1
Female	2	2	2	2
14-49	1	1	1	1
50-64	2	2	2	2
65-74	3	3	3	3
75-80	4	4	4	4
81+	5	5	5	5

Score:

<9 LOW Risk - daily score

10-14 MEDIUM Risk - daily score and SSKIN Bundle care plan

15+ HIGH Risk - daily score, SSKIN Bundle Care Plan & SSKIN Bundle

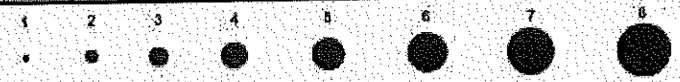
	A	B	C	D
Date				
Time				
Total				

Amended to match new NATVNS Medical Illustration Aug. 2015

Neurological Observation Chart

			Score	Notes
Date:				
Time:				
eyes open		Spontaneously	4	Eyes closed by swelling =C
		To speech	3	
		To pain	2	
		None	1	
Best verbal response	Smiles	Orientated	5	Endotracheal tube or tracheostomy = T
	Cries	Confused	4	
	Inapp. cries	Inapp words.	3	
	Occ wimper	Incomp. sounds	2	
	None	None	1	
Best motor response		Obeys	6	Usually record the best arm response
		Localises	5	
		Flexion to pain	4	
		Abnormal flexion	3	
		Extension to pain	2	
		None	1	
		GCS TOTAL		
PUPILS	**R**	Size		s=sluggish + reacts - no reaction c. eyes closed
		Reaction		
	L	Size		
		Reaction		
LIMB MOVEMENT	**ARMS**	Normal power		Record right (R) and left (L) separately if there is a difference between the two sides
		Mild weakness		
		Severe weakness		
		Extension		
		No response		
	LEGS	Normal power		
		Mild weakness		
		Severe weakness		
		Extension		
		No response		

Coma Scale
Pupil size (mm)



Any of the following examples of neurological deterioration should prompt urgent re-appraisal by a doctor:

- the development of agitation or abnormal behaviour
- a sustained decrease in conscious level of at least one point in the motor or verbal response or two points in the eye opening response of the GCS score
- the development of severe or increasing headache or persisting vomiting
- new or evolving neurological symptoms or signs, such as pupil inequality or symmetry of limb or facial movement

Additional Observations

Height (m)

Date:	
Time:	
Weight: (Kg)	
BMI	

NAUSEA SCORE -
see post op nausea guidelines
0 = None
1 = Intermittent nausea. No treatment required
2 = Nausea and/or vomiting - helped by treatment
3 = Nausea and/or vomiting -persistent despite treatment

SEDATION SCORE
S = Normal sleep
0 = Awake
1 = Mildly sedated, awakes to verbal and touch stimuli
2 = Moderately sedated
3 = Severe-unrousable. Difficult to wake to verbal and touch stimuli

0	1	2	3	4	5	6	7	8	9	10
No pain		Mild		Moderate		Severe		Very Severe		Worst pain ever suffered

	Outline clinical response to NEWS triggers	
NEWS Score	**Frequency of Monitoring**	**Clinical Response**
0	Minimum 12 hourly Or at the discretion of the Medical staff	• Continue routine NEWS monitoring with every set of observations
Total 1 - 4	Minimum 4-6 hourly Or at the discretion of the Medical staff	• Inform registered nurse who must assess the patient ; • Assess Signs of Systemic Inflammation Criteria (SSI) • Registered nurse to decide if increased frequency of monitoring and / or escalation of clinical care is required. • Document action
Total 5 or 6 or 3 in one parameter	Increased frequency to a minimum of 1 hourly	• Registered nurse to urgently inform the nurse in charge. • Urgent assessment by a clinician with core competencies to assess acutely ill patients; (Medical Team caring for patient.) • Clinical care in an appropriate environment; • Complete 4AT assessment • Document action
Total 7 or more	Continuous monitoring of Vital signs	• Registered nurse to immediately inform senior medical staff/GP/ MET who will carry out an emergency assessment. • Consider 2222/999 • Consider transfer of Clinical care to an appropriate care facility. • Document action

Any Raised NEWS-
Please consider the following :

A
- Airway not patent - 2222/999 call and follow BLS guidance
- Airway patent but concern - call local MET team/local escalation policy
- Consider simple airway manoeuvres and airway adjuncts
- Consider suction

B
- Sit patient up - if breathing difficulty
- Consider oxygen therapy, titrate oxygen delivery to sats of 94-98% or 88-92% in severe COPD and adjust NEWS trigger appropriately
- Give nebulised bronchodilator if appropriate and prescribed

C
- Staff nurse/team member to initiate IV access
- If IV access present
  - Is it patent?
  - Is the patient receiving prescribed fluids at the correct rate?
- Lie patient flat if hypotensive/symptomatic
- If concerned about heart rate/arrhythmia or having chest pain please obtain 12 lead ECG
- If SEPSIS initiate sepsis bundle and initiate normal saline fluid challenge according to PGD guidelines
- Check urine output - If less than 30mls per hour
  - Check patient able to pass urine
  - If catheterised check it is patent
  - Consider bladder scan

D
- Please check blood sugar
- If response less than alert record a formal GCS

E
- If you remain concerned please escalate to local MET protocol or other escalation policy

Please consider high risk groups with normal NEWS
- Particularly patients with cardiac chest pain, these should have an ECG and call to the local MET or other escalation policy

Date	Time	NEWS	Comment & Action Taken	Signed
23/10	2230	4	Very low temp H/R 9 Nurse aware	DM
	1000	(1)	Repeat at 1100	KS

Raigmore SCI Store - Patient Result Report

Report ID: 60224405 BBV

Sample Collected: 23/10/2017 15:15:00

Patient

Patient Name	CHI	Date Of Birth	Age	GP	GP Practice	Consultant	Ward/Location
Colin James Kerr	2911796454	29/11/1979	46	TWEEDIE, DAWN	Finlayson Medical Practice		

Report Details

Report Requestor	Requestor Location	ReportIdentifier	Discipline
CONSULTANT, UNKNOWN	(CWCAS) A&E - CAITHNESS	60224405 BBV	Virology
Sample Type	**Sample Collected**	**Sample Received**	**Processed Into Store**
VENOUS BLOOD	23/10/2017 15:15:00	24/10/2017 13:45:56	24/10/2017 17:12:07
Authorised By	**Author**	**Typist**	**Examined By**
N/A	N/A	N/A	N/A
Authorised Date	**Date of reporting**	**Date of typing**	**Examination Date**
N/A	N/A	N/A	N/A
Referral Source	**UCPN**	**Status**	
N/A	N/A	Active	

Report

Blood-borne virus screen — Cumulative

Surname:	KERR	Report ID:	60224405 BBV
Forename:	COLIN JAMES	Sample Collected:	23/10/2017 15:15
DOB:	29/11/1979	Requester:	UNKNOWN CONSULTANT
CHI:	2911796454	Location code:	CWCAS
Gender:	M	Location:	A & E Caithness General Hospital
PAS codes:		Specimen type:	VENOUS BLOOD
Address:	20 BRACKEN LANE, STIRLING, FK9 5AB.	Specimen comment:	
Analysis at:	RAIGMORE	Last Lab. --> SCISTORE transfer at:	24-10-2017 17:12:00

Blood Borne Virus Testing (MICROPARTICLE ENZYME IMMUNOASSAY)

Hepatitis B surface Antigen : Nonreactive
Hepatitis C Antibody : Nonreactive
HIV Antigen/Antibody : Nonreactive
-
Validated by: msumm02 17:11 24 Oct 2017

{EndOfFile}

Last 1 users to access this result

Name	System	Location	Time
S/N Louisa Harper	Raigmore Live	Raigmore SCI Store	25/10/2017 13:35:01

Printed By: Isabel More - Medical Records Manager on 28/05/2026 08:33:43

Raigmore SCI Store - Patient Result Report

Report ID: 30351734 TT3

Sample Collected: 23/10/2017 15:15:00

Patient

Patient Name	CHI	Date Of Birth	Age	GP	GP Practice	Consultant	Ward/Location
Colin James Kerr	2911796454	29/11/1979	46	TWEEDIE, DAWN	Finlayson Medical Practice		

Report Details

Report Requestor	Requestor Location	ReportIdentifier	Discipline
CONSULTANT, UNKNOWN	(CWCAS) A&E - CAITHNESS	30351734 TT3	BIOCHEMISTRY SENDAWAY
Sample Type	**Sample Collected**	**Sample Received**	**Processed Into Store**
BLOOD	23/10/2017 15:15:00	23/10/2017 15:48:58	24/10/2017 15:27:09
Authorised By	**Author**	**Typist**	**Examined By**
N/A	N/A	N/A	N/A
Authorised Date	**Date of reporting**	**Date of typing**	**Examination Date**
N/A	N/A	N/A	N/A
Referral Source	**UCPN**	**Status**	
N/A	N/A	Active	

Report

Total T3 (Tri-idothyronine)

Surname: KERR
Forename: COLIN JAMES
DOB: 29/11/1979
CHI: 2911796454
Gender: M
PAS codes:
Address: 20 BRACKEN LANE, STIRLING, FK9 5AB.

Report ID: 30351734 TT3
Sample Collected: 23/10/2017 15:15
Requester: UNKNOWN CONSULTANT
Location code: CWCAS
Location: A & E Caithness General Hospital
Specimen type: BLOOD
Specimen comment:

Analysis at: RAIGMORE

Last Lab. --> SCISTORE transfer at:24-10-2017 15:27:08

Clinical Details :
###Clinical history suppressed here (if entered by lab.)###

Assayed at Biochemistry Dept. Glasgow Royal Infirmary.
Total T3 not indicated by TSH and Free T4 results. TSH is is only just below the reference interval. Phone Duty Biochemist if you wish to discuss ext 5931
H. Mendoza
Note amended report. Interpretative comment added
-
Validated by: hmend01 15:27 24 Oct 2017

{EndOfFile}

Set Comments

Total T3 not indicated by TSH and Free T4 results. TSH is is only just below the reference interval. Phone Duty Biochemist if you wish to discuss ext 5931
H. Mendoza
{Note amended report. Interpretative comment added{

Last 2 users to access this result

Name	System	Location	Time
S/N Louisa Harper	Raigmore Live	Raigmore SCI Store	25/10/2017 13:35:32
Catriona Gibb - FY2	Raigmore Live	Raigmore SCI Store	24/10/2017 15:34:35

Printed By: Isabel More - Medical Records Manager on 28/05/2026 08:34:08

Raigmore SCI Store - Patient Result Report

Report ID: 30351734 TFT

Sample Collected: 23/10/2017 15:15:00

This report has history

Patient

Patient Name	CHI	Date Of Birth	Age	GP	GP Practice	Consultant	Ward/Location
Colin James Kerr	2911796454	29/11/1979	46	TWEEDIE, DAWN	Finlayson Medical Practice		

Report Details

Report Requestor	Requestor Location	ReportIdentifier	Discipline
CONSULTANT, UNKNOWN	(CWCAS) A&E - CAITHNESS	30351734 TFT	Biochemistry
Sample Type	**Sample Collected**	**Sample Received**	**Processed Into Store**
BLOOD	23/10/2017 15:15:00	23/10/2017 15:48:58	24/10/2017 10:50:02
Authorised By	**Author**	**Typist**	**Examined By**
N/A	N/A	N/A	N/A
Authorised Date	**Date of reporting**	**Date of typing**	**Examination Date**
N/A	N/A	N/A	N/A
Referral Source	**UCPN**	**Status**	
N/A	N/A	Active	

Report

Thyroid Function Tests — Cumulative

Surname:	KERR	Report ID:	30351734 TFT
Forename:	COLIN JAMES	Sample Collected:	23/10/2017 15:15
DOB:	29/11/1979	Requester:	UNKNOWN CONSULTANT
CHI:	2911796454	Location code:	CWCAS
Gender:	M	Location:	A & E Caithness General Hospital
PAS codes:		Specimen type:	BLOOD
Address:	20 BRACKEN LANE, STIRLING, FK9 5AB.	Specimen comment:	
Analysis at:	CAITHNESS	Last Lab. --> SCISTORE transfer at:	24-10-2017 10:49:53

Clinical Details:
###Clinical history suppressed here (if entered by lab.)###

Free T4 11.4 pmol/L (9 - 24)

T S H 0.30 mIU/L *L(0.34 - 5.4)
-
Validated by: hmend01 10:49 24 Oct 2017

{EndOfFile}

Last 2 users to access this result

Name	System	Location	Time
S/N Louisa Harper	Raigmore Live	Raigmore SCI Store	25/10/2017 13:35:33
Catriona Gibb - FY2	Raigmore Live	Raigmore SCI Store	24/10/2017 15:13:14

Printed By: Isabel More - Medical Records Manager on 28/05/2026 08:34:20

Raigmore SCI Store - Patient Result Report

Report ID: 30351734 B

Sample Collected: 23/10/2017 15:15:00

Patient

Patient Name	CHI	Date Of Birth	Age	GP	GP Practice	Consultant	Ward/Location
Colin James Kerr	2911796454	29/11/1979	46	TWEEDIE, DAWN	Finlayson Medical Practice		

Report Details

Report Requestor	Requestor Location	ReportIdentifier	Discipline
CONSULTANT, UNKNOWN	(CWCAS) A&E - CAITHNESS	30351734 B	Biochemistry
Sample Type	**Sample Collected**	**Sample Received**	**Processed Into Store**
BLOOD	23/10/2017 15:15:00	23/10/2017 15:48:58	23/10/2017 16:57:23
Authorised By	**Author**	**Typist**	**Examined By**
N/A	N/A	N/A	N/A
Authorised Date	**Date of reporting**	**Date of typing**	**Examination Date**
N/A	N/A	N/A	N/A
Referral Source	**UCPN**	**Status**	
N/A	N/A	Active	

Report

General biochemistry composite — Cumulative

Surname:	KERR	Report ID:	30351734 B
Forename:	COLIN JAMES	Sample Collected:	23/10/2017 15:15
DOB:	29/11/1979	Requester:	UNKNOWN CONSULTANT
CHI:	2911796454	Location code:	CWCAS
Gender:	M	Location:	A & E Caithness General Hospital
PAS codes:		Specimen type:	BLOOD
Address:	20 BRACKEN LANE, STIRLING, FK9 5AB.	Specimen comment:	

Analysis at: CAITHNESS

Last Lab. --> SCISTORE transfer at:23-10-2017 16:57:18

Sodium 140 mmol/L (133 - 146)
Potassium 4.2 mmol/L (3.5 - 5.3)
Chloride 103 mmol/L (95 - 108)
Bicarbonate 30 mmol/L *H(22 - 29)
Urea 4.6 mmol/L (2.5 - 7.8)
Creatinine 67 umol/L (50 - 120)
Estimated GFR >60 ml/min/1.73m^2 .
Bilirubin 6 umol/L (< 21)
Alk. Phos. 81 u/L (30 - 130)
ALT 28 u/L (5 - 55)
Albumin 46 g/L (35 - 50)
C-Reactive Protein 12 mg/L *H0 - 9)

Clinical Details:
###Clinical history suppressed here (if entered by lab.)###
-
Validated by: Autovalidated_CLINK 16:57 23 Oct 2017

{EndOfFile}

Last 1 users to access this result

Name	System	Location	Time
S/N Verity Mackay	Raigmore Live	Raigmore SCI Store	23/10/2017 19:44:50

Printed By: Isabel More - Medical Records Manager on 28/05/2026 08:35:17

Raigmore SCI Store - Patient Result Report

Report ID: 30351734 GLU

Sample Collected: 23/10/2017 15:15:00

Patient

Patient Name	CHI	Date Of Birth	Age	GP	GP Practice	Consultant	Ward/Location
Colin James Kerr	2911796454	29/11/1979	46	TWEEDIE, DAWN	Finlayson Medical Practice		

Report Details

Report Requestor	**Requestor Location**	**ReportIdentifier**	**Discipline**
CONSULTANT, UNKNOWN	(CWCAS) A&E - CAITHNESS	30351734 GLU	Biochemistry
Sample Type	**Sample Collected**	**Sample Received**	**Processed Into Store**
PLASMA	23/10/2017 15:15:00	23/10/2017 15:48:58	23/10/2017 16:48:58
Authorised By	**Author**	**Typist**	**Examined By**
N/A	N/A	N/A	N/A
Authorised Date	**Date of reporting**	**Date of typing**	**Examination Date**
N/A	N/A	N/A	N/A
Referral Source	**UCPN**	**Status**	
N/A	N/A	Active	

Report

Glucose — Cumulative

Surname: KERR
Forename: COLIN JAMES
DOB: 29/11/1979
CHI: 2911796454
Gender: M
PAS codes:
Address: 20 BRACKEN LANE, STIRLING, FK9 5AB.
Analysis at: CAITHNESS

Report ID: 30351734 GLU
Sample Collected: 23/10/2017 15:15
Requester: UNKNOWN CONSULTANT
Location code: CWCAS
Location: A & E Caithness General Hospital
Specimen type: PLASMA
Specimen comment:
Last Lab. --> SCISTORE transfer at:23-10-2017 16:48:47

Glucose 5.5 mmol/l (Random: 3.5-5.5)

Validated by: Autovalidated_CLINK 16:48 23 Oct 2017

{EndOfFile}

Last 1 users to access this result

Name	System	Location	Time
S/N Verity Mackay	Raigmore Live	Raigmore SCI Store	23/10/2017 19:45:38

Printed By: Isabel More - Medical Records Manager on 28/05/2026 08:35:31

Raigmore SCI Store - Patient Result Report

Report ID: 30351734 FBC **Sample Collected:** 23/10/2017 15:15:00

Patient

Patient Name	CHI	Date Of Birth	Age	GP	GP Practice	Consultant	Ward/Location
Colin James Kerr	2911796454	29/11/1979	46	TWEEDIE, DAWN	Finlayson Medical Practice		

Report Details

Report Requestor	Requestor Location	ReportIdentifier	Discipline
CONSULTANT, UNKNOWN	(CWCAS) A&E - CAITHNESS	30351734 FBC	Haematology
Sample Type	**Sample Collected**	**Sample Received**	**Processed Into Store**
BLOOD	23/10/2017 15:15:00	23/10/2017 15:48:58	23/10/2017 16:27:40
Authorised By	**Author**	**Typist**	**Examined By**
N/A	N/A	N/A	N/A
Authorised Date	**Date of reporting**	**Date of typing**	**Examination Date**
N/A	N/A	N/A	N/A
Referral Source	**UCPN**	**Status**	
N/A	N/A	Active	

Report

FULL BLOOD COUNT Cumulative

Surname:	KERR	Report ID:	30351734 FBC
Forename:	COLIN JAMES	Sample Collected:	23/10/2017 15:15
DOB:	29/11/1979	Requester:	UNKNOWN CONSULTANT
CHI:	2911796454	Location code:	CWCAS
Gender:	M	Location:	A & E Caithness General Hospital
PAS codes:		Specimen type:	BLOOD
Address:	20 BRACKEN LANE, STIRLING, FK9 5AB.	Specimen comment:	

Analysis at: CAITHNESS Last Lab. --> SCISTORE transfer at:23-10-2017 16:27:36

Clinical Details: ###Clinical history suppressed here (if entered by lab.)##
10^9/L
Haemoglobin 171 g/L *H(133 - 167) White Cells 8.1 (4.0 - 11.0)
RBC 5.26 10^12/L (4.3 - 5.7) Neutrophils 6.5 (2.0 - 7.5)
HCT 0.497 (0.39-0.50) Lymphocytes 1.2 *L(1.5 - 4.0)
MCV 94.4 fl (80.0-98.0) Monocytes 0.3 (0.2 - 1.0)
MCH 32.6 pg *H(27.0-32.0) Eosinophils 0.0 *L(0.1 - 0.7)
MCHC 345 g/L (310 - 360) Basophils 0.1 (0.0 - 0.2)
RDW 15.1 % *H(10.0-14.0) Myelocytes
%HYPO 0.1 Promyelocytes
PLATELETS 362 10^9/L (150 - 450)
MPV 7.0 fl
-
Validated by: Autovalidated_CLINK 16:27 23 Oct 2017

{EndOfFile}

Last 1 users to access this result

Name	System	Location	Time
S/N Verity Mackay	Raigmore Live	Raigmore SCI Store	23/10/2017 19:45:43

Printed By: Isabel More - Medical Records Manager on 28/05/2026 08:35:44

[redacted]

NHS HIGHLAND **MEDICINE**

Hospital..................................

CONTINUATION SHEET

CHI: 2911796464
KERR
COLIN
M 29/11/1979 R773621
20 BRACKEN LANE
STIRLING
FK9 5AB

DATE	CLINICAL NOTES
24/10/17 1030	WR Dr Ahmed
	Admitted with alcohol withdrawal
	Feels rough today, anxious
	Has been losing weight
	Normally has good appetite, unable to eat today
	Injects heroin - ongoing for ~10 years
	- started due to mental problems
	Able to heel-toe walk
	Lost his job, currently homeless
	Plan - Home
	- Psych referral as outpatient
	- Add on total T3
	- crisis team referral
	- social work [signature] FY2 C. GIBB 540
25/10/17 0925	WR Dr Ahmed
	Awaiting review by drug & alcohol services today
	They reviewed yesterday - nothing documented
	Today feels no better
	Seems willing to engage with services
	Plan - await plan from drug/alcohol services
	- continue diazepam scoring
	- consider anti-emetic [signature] FY2 C. GIBB 540

DISCHARGE NOTIFICATION

NHS Highland

Hospital: Caithness General Date: 25/10/2017 13:55 Discharge ID: 644853

Dr Clark
Bridge Of Allan Health Centre
Fountain Road
Bridge Of Allan
FK9 4EU

Notes Copy

Colin Kerr 29/11/1979 Unit No: 2911796454 CHI No: 2911796454
20 BRACKEN LANE, Stirling, Stirlingshire, FK9 5AB,

Date of Admission:	23/10/2017	Consultant:	DR WYBREW, ROBIN	Specialty:	GENERAL MEDICINE
Date of Discharge:	25/10/2017	Ward:	ROSEBANK	Ward Tel:	01955 605050 Ext 308

Medication on discharge: (POS - Patient's Own Supply)

Drug	Dose	Frequency	Days	Route	GP Continue?
Admission drugs (discontinued)					
Admission drugs (unamended)					
OMEPRAZOLE Capsules *(Indications: acute prescription on 3rd oct)*	20mg	twice a day	POS	oral	Review
Admission drugs (amended)					
Drugs prescribed since admission					

Clinical and Management Information

Mode Of Admission:	Emergency
Main Condition:	Withdrawal (Withdrawal)
Current Active Problems:	reflux oesophagitis Heroin & alcohol abuse
Operations / Procedures:	bloods (.)
Allergies:	nkda
Clinical Comments for GP / Notes:	Dear Dr, Colin was taken to Ed in Caithness on the 23rd of october by Police, as he had been dismissed from employment at a local hotel and refused to leave the building.. When police were at scene he stated he was suicidal. In Ed Colin stated he had been drinking up to two bottles of vodka daily for the previous 3 days and withdrawing from heroin due to unavailability in the area. Colin has recently seperated from his wife this is when he started to use heroin again. During admission he was treated for alchohol withdrawl with i.v pabrinex and diazepam with no issues. observations have been stable during admission. Colin has been seen by local Community psyciatric nurse, who tried to find emergency housing locally. Unfortunatley Colin did not fit the criteria for this and was put in touch with the Welfasre fund for Scotland who have arranged a payment of monies so Colin can get back to Stirling today.
Awaited Results:	nil
Patient Aware of Diagnosis:	Yes
Med 3 Fitness to Work Certificate:	Not Required
FDL to follow:	No
OP Booking Required:	No ✓ ECA
Destination on Discharge:	Temporary address

Nursing Information

MRSA	Not Applicable

Authorising Clinician: Louisa Harper

I, the undersigned, have given an explanation of nursing care to: Patient/Representative of Kerr (2911796454).

Nurse's Signature:	Date:

Patient / Carer *(delete as appropriate)*: **the above information has been discussed with me.**

Patient / Carer Signature:	Date:

I agree

DISCHARGE NOTIFICATION

Hospital: Caithness General

Date: 25/10/2017 13:56

NHS Highland
Discharge ID: 644853

Dr Clark
Bridge Of Allan Health Centre
Fountain Road
Bridge Of Allan
FK9 4EU

GP Copy

Colin Kerr 29/11/1979 Unit No: 2911796454 CHI No: 2911796454
20 BRACKEN LANE, Stirling, Stirlingshire, FK9 5AB,

Date of Admission:	23/10/2017	Consultant:	DR WYBREW, ROBIN	Specialty:	GENERAL MEDICINE
Date of Discharge:	25/10/2017	Ward:	ROSEBANK	Ward Tel:	01955 605050 Ext 308

Medication on discharge:

(POS - Patient's Own Supply)

Drug	Dose	Frequency	Days	Route	GP Continue?
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Admission drugs (unamended)					
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Drugs prescribed since admission					

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Awaited Results:	nil
Patient Aware of Diagnosis:	Yes
Med 3 Fitness to Work Certificate:	Not Required
FDL to follow:	No
OP Booking Required:	No
Destination on Discharge:	Temporary address

Nursing Information

MRSA	Not Applicable

SENSITIVE

Department of General Medicine
Caithness General Hospital
Bankhead Road
Wick
Caithness
KW1 5NS
Tel: 01955 880361

www.nhshighland.scot.nhs.uk

NHS Highland

Dr C Clark
Bridge Of Allan Health Centre
Fountain Road
Bridge Of Allan
FK9 4EU

Our Ref: AK/ERA/
Date Dictated: 01/11/2017
Date Typed: 01/11/2017

2911796454

Dear Dr Clark,

Colin Kerr **DOB: 29/11/1979** **CHI: 2911796454**
20 Bracken Lane, Stirling, Stirlingshire, FK9 5AB

Date of admission: 23/10/17
Date of discharge: 25/10/17

I agree with the immediate discharge letter for the above admission.

Yours sincerely

Prof A Khan
Locum Consultant Physician

Authorised on 03/11/2017 13:05:42 by Typist Eleanor Allan, not verified by the author.