(PART 1 of 2)

ELECTRONIC PATIENT RECORDS

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

Including:

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

My Admission Record

NHS Greater Glasgow and Clyde

Name: _____
Address: 1203893450
WEIR M
James 12/03/1989
27D MACDOWALL STREET
Johnstone, Renfrewshire
DoB: ___ PA5 8QJ
CHI: ___
Affix patient label

Hospital: RAH Ward: AMU
Date of Admission: 10/6/20 Time: 1905
Information obtained from: Name:
Patient ☑ Relative ☐ Other ☐ _____
Preferred Name:
Age: 31 Telephone Number:
Consultant:

62kg SAT Ram green

Communication

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

Preferred first contact	Preferred second contact
Name: Deborah Weir	Name:
Relationship: Sister	Relationship:
Address:	Address:
Telephone: 07 306 306678	Telephone:
Is this person aware of your admission? Yes ☑ No ☐	Is this person aware of your admission? Yes ☐ No ☐
Can we share information with this person? Yes ☑ No ☐	Can we share information with this person? Yes ☐ No ☐

Presenting Complaint / Diagnosis

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

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

No known allergies ☐ Penicillin

Relevant past medical history

Emotionally Unstable Personality Disorder

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

Power of Attorney / Guardianship / Adult with Incapacity

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

Yes ☐ No ☑

OR

Does someone have Guardianship?

Yes ☐ No ☑

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

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

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

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

POA/ Guardian

Name: _____ Relationship: _____ Contact Tel Number _____

Name: _____ Relationship: _____ Contact Tel Number _____

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

Carbapenemase-producing enterobacteriaceae (CPE)

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

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

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

MRSA Screening

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

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

Nasal ☐ Perineum ☐ Other ☐ Specify _____ Patient refused ☐

Creutzfeldt-Jakob Disease (CJD)

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

If **YES inform the IPCT** ☐

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Lifestyle

Smoking

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

Never smoked ☐

Do you use eCigarettes? Yes ☐ No ☑

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

Yes - administered NRT ☐ Yes - patient declined NRT ☐

If declined - Why: _____

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

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

Drugs

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

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

Cannabis

Alcohol

Do you drink alcohol? Yes ☑ No ☐

How often do you have more than 6 units of alcohol on one occasion: >10 units

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

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

Name (Please PRINT): ASparkes Signature: ASparkes

Designation: S/N Date: 10/6/2020

My Assessment Record

Name: [redacted]
Addres [redacted]
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M
12/03/1989
DoB: [redacted]
CHI: [redacted]
Affix pa[redacted]

1. Breathing and Circulation

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

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

2. Communication

	Yes ✓	No ✓	Assessment of the patient's communication needs
Do you have any difficulties communicating your needs?			Patient struggles to read and write so can have difficulty with words.
Do you have any difficulties with your speech?			
Do you have a Learning Disability?			
Do you have support from a Learning Disability Team? Contact details: _____			

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3. Senses

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

Can you describe where and what the pain is like?

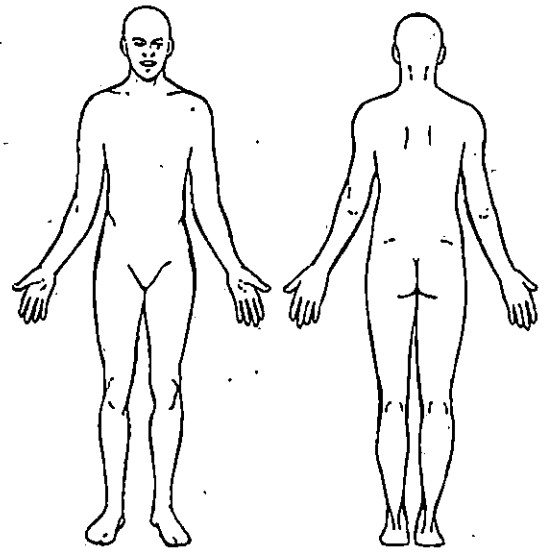
Have you had treatment / intervention for the pain?

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

Can you describe any chronic pain that you have?

What makes the pain better?

Mark current pain on body chart



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4. Cognitive Status THINK DELIRIUM

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

N.B. Think Delirium

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

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

and follow the guidance

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

5. Hydration and Nutrition

Do you have any food allergies or food intolerances?

No

What do you like to eat and drink?

Not fussy

What do you not like to eat and drink?

Not fussy

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

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

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Assessment of the patient's hydration and nutrition needs

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

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

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

6. Elimination

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

Assessment of the patient's elimination needs

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

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

What products do you normally use for this continence issue?

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

Date urinary catheter last changed ___/___/___

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

Bowels

When did your bowels last move? 10/6/2020

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

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

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

What products do you normally use for this continence issue?

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

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

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

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

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

Pressure ulcer identified on admission: Yes ☐ No ☐

Pressure Ulcer Grade: _____

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

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

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

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8. Mobility

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

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

9. Maintaining a Safe Environment

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

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

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

10. Sleep and Rest

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

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11. Social Circumstances

Do you:

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

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

If no support available contact Duty Social Worker

Duty Social Worker Required ☐ Not required ☐ Referred ☐

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

12. Emotional and Spiritual Care

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

No

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

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

Healthcare Chaplain informed Yes ☐ N/A ☑

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13. Person Centred Care

What matters and is important to you whilst you are in hospital?
This should focus on the personal preferences, choices and goals of the individual of what is important to include in their plan of care.

Getting help

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

Informal Support

Who is important to you, to help support you whilst you are in hospital?

My sister and brother

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

Name: .....

Contact Details: .....

.....

.....

How do you want the people who matter to you to be involved in your care?

Do you have someone who looks after you or someone that helps you, i.e. an informal carer?

Yes ☐ No ☐

If yes, has the help or support listed above been confirmed with the patient's family/ friends?
(please tick) Yes ☐ No ☐

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Required Support

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

Yes ☐ No ☑

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

Has the carer been advised of the Carers Information Line?

Yes ☐ No ☑ Not appropriate at this time ☐

Carers Information Line: 0141 353 6504

Carers Information Leaflet provided?

Yes ☐ No ☑

Are you:

Employed ☐ Unemployed ☑

Self-employed ☐ Retired ☐

Full time education ☐

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

Yes ☐ No ☐ Not applicable ☑

Do you have any money worries?

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

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

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

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

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

If yes when was patient referred ___/___/___

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Risk Assessments/Other Documentation

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

Clinical Notes

Date and Time	Notes	Print Name, Signature and Designation
10/6/2020 1925	Patient brought to A&E, stopped drinking yesterday has been emitted and tremulous since. This morning drank 1 bottle of wine on advice of mental health team. Vomited several times followed by haematemesis. Patient determined to stop drinking and	

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Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation
	wants to become mental health nurse.	
	States drinking due to sexual abuse	
	and sees abuser daily in street.	
	States suicidal ideation but what	
	has stopped him is support from	
	sister and neice.	
Investigations:	bloods	
Diagnosis:	- alcohol withdrawal	
	- ?? UGI bleed	
Plan:	- IV Pabrinex	
	- CIWA-Ws	
AMU:	On arrival to AMU patient transferred	
	to bed ~~area~~ independantly. Very	
	tearful and emotional - alert and	
	chatty but reluctant to talk. Wants	
	help to stop drinking. NEWS ① temp	C Spence
	35.9°. CIWA-Ws 0. Await review.	C Spence
11/6/20	Reviewed by cons Dr Gavil @ 20[illegible]	
0200	- alc withdrawal	
	PLAN - CIWA-Ws & Fixed dose	
	- Pabrinex	
	- alc liaison.	
	- ANY MED	
	Further reviewed by reg	
	Pt highly emotional, anxious &	
	tearful. could benefit from ↓	
	input but need to address	→

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Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation
	alcohol withdrawal 1st d adm	
	Rec further 2mg diazepam IV	
	- analgesia	
	- anti-emetic	
	- IV fluids	
	Pt become verbally aggressive	
	towards staff as another pt was	
	in the room laughing & joking	
	with staff. I advised that this	
	was part of patient care & repour.	
	Pt proceeded to pull bung off	
	ventan - walking through ward	
	& flood everywhere. removed ventan	
	applied pressure showing @ staff	
	Pt put clothing on & left ward.	
	represented to CO - advised	
	return to ward on grounds that	
	that benaviour would not be	
	tolerated & asked to leave.	
	Settled into bed initially -	
	another pt in the room confused	
	pt then became threating to	
	the other pt & staff - pt	
	asked to leave room. He	
	demanded to speak to management	
	Bed manager on ward - Spoke	
	with pt - No signs of withdrawal	

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☐ NURSING ☑

Please tick ✔ appropriate directorate

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Date & Time		Signature, Print Name & Designation
cont	Pt asked to leave. On leaving ward he proceeded to kick main ward door & left - Represented into ED again. We advised that he has been discharged - Pt had lost phone. It has now been found. In lost property on ward - Pt no longer in ED to return phone to him.	(illegible) SN

83949 GCC0072

Date & Time		Signature, Print Name & Designation

Record of Communication with Relatives / Carers

NHS Greater Glasgow and Clyde

This form should be stored at the front of the patient's nursing notes during the period of admission and then filed on discharge.

Hospital:	Ward:

Name: .....
Address: .....
.....
DoB: .....
Chi number:

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Affix patient details

Support and Care Arrangements	No Carer identified ✓ If NO following section N/A	
IDENTIFYING	Yes ✓	No ✓
Have support and care arrangements been confirmed with relative / carer? N.B. record details below including details of any existing support plans		
INVOLVING	Yes ✓	No ✓
Have progress and on-going support needs been discussed with relative / carer?		
Have the carer's views / opinions / requests on discharge plan been noted?		
Has the carer given consent to share their views with the patient?		
SUPPORTING	Yes ✓	No ✓
Has the carer been advised of what support is available to them?		
Has the "Are you looking after someone?" flyer been given to the carer?		
Have you referred to a support service?		
Has the offer of support been declined by the carer?		

Record Name of who discussed with; details of discussion; action agreed.

Date	Record of Communication	Print and Sign Name	Staff Code

Staff Codes: **N** – Nursing. **M** – Medical. **P** – Physiotherapist. **OT** – Occupational Therapist. **SW** – Social Worker. **SLT** – Speech and Language Therapist. **D** – Dietician. **O** – Other.

Carers Information Line: 0141 353 6504
NHSGGC Support & Information Services: 0141 452 2387

Record Name of who discussed with; details of discussion; action agreed.			
Date	Record of Communication	Print and Sign Name	Staff Code

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Care Plan

NHS
Greater Glasgow and Clyde

Date Commenced and Signature	7. Personal Hygiene, oral care, skin care and wound care	Date Discontinued and Signature	Date Commenced and Signature	9. Maintaining a safe environment, Technical Care	Date Discontinued and Signature
10/6/2020 [signature]	Independent.		10/6/2020 [signature]	Call buzzer to hand.	
				10. Sleep and Rest	
				Not kept for days	
	8. Mobility				
	Independent.			12. Privacy, dignity and sexuality	
				Maintain at all times	
				Negotiated care - Please record any planned involvement of patient/family in delivery of care	

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Care Plan

NHS Greater Glasgow and Clyde

Care discussed with patient ☐ Yes ☐ No ☐ Unable			If unable, give reason:		
Care discussed with family ☐ Yes ☐ No ☐ Unable			If unable, give reason:		
Date commenced & signature	1. Breathing and circulation	Date discontinued & signature	Date commenced & signature	Getting to Know Me / What Matters to Me	Date discontinued & signature
10/6/2020 [signature]	No urinary issues		10/6/2020 [signature]		
				5. Hydration and Nutrition	
				Normal diet and fluids	
	2, 3. Communication and senses				
	Can communicate needs, very verbal. Wears glasses at all times.				
				6. Elimination	
	4. Cognitive status			Continent. Independent.	
	Alert + orientated.				

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FALLS RISK ASSESSMENT

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

NHS Greater Glasgow and Clyde

GENERAL SAFETY PRECAUTIONS
TO BE UNDERTAKEN FOR ALL PATIENTS

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

	Ward: RMO Date: 10/6/20 Time: 19:10	Ward: Date: Time: -----:-----	Ward: Date: Time: -----:-----	Ward: Date: Time: -----:-----	Ward: Date: Time: -----:-----
1. Document mobility status in clinical record and complete a moving and handling assessment (if appropriate).	✓				
2. Check walking aid (if required) is in reach and in use.	X				
3. Check call bell is in reach and working. Provide and document alternative measures if patient is unable to use call bell.	✓				
4. Check footwear is safe (refer to NHSGGC Footwear guidance).	✓				
5. If glasses are worn, check they are available and in use.	✓				
6. If hearing aid/s are worn, check they are working and in use.	X				

RISK ASSESSMENT

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

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

Highlight risk of fall at the ward safety brief.

Patient Details

FALLS INTERVENTION CHECKLIST

NHS Greater Glasgow and Clyde

Complete for all patients identified at risk of falling.

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

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

EVIDENCE ALL INTERVENTIONS IN NURSING CARE PLAN

Pressure Ulcer Daily Risk Assessment (PUDRA)

NHS Greater Glasgow and Clyde

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

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

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

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

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

Date	Time	Pressure Damage	Mobility	Continence	Nutrition	Skin Compromised	Clinical Judgement	Care Prescribed	Signature
10/6/20	19:10	N	N	N	N	N	N	4 hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	

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

Prevention of Pressure Ulcer Inte. .entional Plan

NHS Greater Glasgow and Clyde

Attach Addressograph

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

Outcome: To prevent pressure ulcer development through establishment of effecting work practices in line with SSKINS bundle.

	S SKIN INSPECTION	S SURFACE	K KEEP MOVING	I INCREASED MOISTURE AND CONTINENCE MANAGEMENT	N NUTRITION	S SELF MANAGEMENT / SHARED CARE	Sign / Comments
Date of plan:	Check: • Pressure areas _____ hourly. • Skin under medical devices _____ hourly. • Specify medical devices used:	Specify: • Mattress: • Cushion: • Detail additional pressure redistributing equipment:	• Reposition _____ hourly in bed and chair. • Overnight patient / carer has agreed to repositioning _____ hourly • Specify any manual handling equipment used:	• Skin care to be carried out _____ hourly. • Specify products required for increased moisture / continence management:	• Optimise nutrition and hydration. • Refer to MUST	• Discuss and agree plan with patient / family/ carer YES ☐ NO ☐ • "Prevent Pressure Ulcers" leaflet given to patient / family / carer? YES ☐ NO ☐	Date discontinued: _____
Date Reviewed:	Check: • Pressure areas _____ hourly. • Skin under medical devices _____ hourly. • Specify medical devices used:	Specify: • Mattress: • Cushion: • Detail additional pressure redistributing equipment:	• Reposition _____ hourly in bed and chair. • Overnight patient / carer has agreed to repositioning _____ hourly • Specify any manual handling equipment used:	• Skin care to be carried out _____ hourly. • Specify products required for increased moisture / continence management:	• Optimise nutrition and hydration. • Refer to MUST	• Discuss and agree updated plan with patient / family/ carer YES ☐ NO ☐ • "Prevent Pressure Ulcers" leaflet given to patient / family / carer? YES ☐ NO ☐	Date discontinued: _____
Date Reviewed:	Check: • Pressure areas _____ hourly. • Skin under medical devices _____ hourly. • Specify medical devices used:	Specify: • Mattress: • Cushion: • Detail additional pressure redistributing equipment:	• Reposition _____ hourly in bed and chair. • Overnight patient / carer has agreed to repositioning _____ hourly • Specify any manual handling equipment used:	• Skin care to be carried out _____ hourly. • Specify products required for increased moisture / continence management:	• Optimise nutrition and hydration. • Refer to MUST	• Discuss and agree updated plan with patient / family/ carer YES ☐ NO ☐ • "Prevent Pressure Ulcers" leaflet given to patient / family / carer? YES ☐ NO ☐	Date discontinued: _____

Care Rounds Checklist

Date: 10/6/2020

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

1. Signed [signature] Name [illegible] Designation SN
2. Signed _____ Name _____ Designation _____
3. Signed _____ Name _____ Designation _____

Attach Addres

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

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

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

Care Rounds Variance Sheet

Attach Addressograph Label

Ward:

NHS Greater Glasgow and Clyde

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

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MALNUTRITION UNIVERSAL SCREENING TOOL (MUST)

NHS Greater Glasgow and Clyde

Date 10/6/20 Time 1910 of initial height and weight on admission to hospital		Actual	*Patient reported	*If unable to obtain height and / or weight (check portal / trak for previous weights) document alternative measures and use subjective criteria to assess risk of malnutrition
Admission Height	177 cm	☑	☐	
Admission Weight	62 Kg	☑	☐	

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

Patients reported normal weight _____ Unable to Recall ☐

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

Date	10/6/20							
Time	1910							
Ward	RMO							
Oedema/ Ascities present Y/N	N							
Scales Used ST = Standing, CH = Chair HT = Hoist, UW = Unable to weigh, record reason and document subjective assessment of risk in nursing notes	CH							
Weight (kgs)	62							
BMI	21.4							
Malnutrition Universal Screening Tool (MUST) to be completed at least every 7 days								
Step 1 BMI Score >20 = 0 18.5-20 = 1 <18.5 = 2	0							
Step 2 Weight loss score <5% = 0 5-10% = 1 >10% = 2	0							
Step 3 Acute disease effect If patient is acutely ill and there has been or is likely to be no, or virtually no, food intake for > 5 days.....Score 2 Not applicable.....Score 0	0							
Step 4 Overall Risk of Malnutrition TOTAL	0							
Rescreen on	17/6/20							
Signature	[signature]							

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

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

MUST STEP 5 Management Guidelines

MUST 1

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

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

YES

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

YES

- Discontinue food and drink recording chart, documenting reason in nursing notes.
- Continue with '**food first**' approach as above.
- Rescreen at least every 7 days.

NO

- Encourage higher calorie menu choices indicated with ✪
- Continue with food and drink recording chart for 4 days, and if no improvement in intake, rescreen.

NO

Complete the above steps

MUST 2 OR GREATER

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

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

YES

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

YES

- Discontinue food and fluid chart, documenting reason in nursing notes.
- Continue with 'food first' approach as above.
- Rescreen at least every 7 days.

NO

Is the patient dying?

YES

- Discontinue food and drink recording chart.
- Stop screening.
- Offer food and fluid as appropriate.

NO

- Continue with food and drink recording chart.
- Screen at least every 7 days.
- Consider referral to dietetics via Trakcare.

NO

Complete the above steps

DISCHARGE

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

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

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Pers WEIR M nt) Moving and Handling Assessment Form

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Johnstone, Renfrewshire
PA5 8QJ

Person's Name:	amed urse:	Person is totally independent (tick here and go to data box) ✓

1. General Information

Body Build		
Weight	Height	Problems with comprehension, behaviour, co-operation (specify):
62 Kg	5ft 7 cm	Handling constraints, e.g. disability, weakness, pain, skin lesions, infusions (specify):
21.4 BMI		
Risk of Falls: Yes	No	

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

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

3. Toileting

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

4. Move on / off bed pan

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

5. Move up / down bed

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

6. Lateral Transfer to / from trolley / bed

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

7. Sit up over side of bed

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

8. Into Bath or Shower

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

9. Walking

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

10. Other Instructions / Observations / Equipment Used

	1st Assessment	2nd Assessment	3rd Assessment
Recording Symbol:	/ Forward slash	X Where a forward slash exists, add a back slash to make a cross	* Where a slash or cross exists add slashes to make a star
Date Assessed:	10/6/2020		
Assessor's signature:	[signature]		
Proposed Review date:	17/6/2020		

Continuation Sheet

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

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

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

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

3. Toileting

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

4. Move on / off bed pan

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

5. Move up / down bed

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

6. Lateral Transfer to / from trolley / bed

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

7. Sit up over side of bed

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

8. Into Bath or Shower

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

9. Walking

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

10. Other Instructions / Observations / Equipment Used

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

Adult Peripheral Vascular Cannula

Insertion and Maintenance Care Plan

Write or affix patient label

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James 12/03/1989
27D MACDOWALL STREET
Johnstone, Renfrewshire
PA5 8QJ

Name: _____
DOB: _____
Ward: _____

NHS Greater Glasgow and Clyde

Insertion criteria: Please complete this section at time of insertion.

Intravascular devices are associated with an increased risk of phlebitis, thrombosis, local infection and bacteraemia and therefore should only be inserted if essential for ongoing care. To help with this decision, please use the criteria listed below (DRIFT) to justify the need for your patient to have a PVC. (Please see back of care plan for further information on DRIFT) Please tick all clinical criteria that apply:

Diagnostics ☐ Resuscitation/Chest Pain ☐ IV Drugs ☐ Fluids ☐ Transfusion ☐

PVC inserted: Day 0	Date: 10/6/20 Hospital: RAH Area: ED ☑ Theatre ☐ ITU/HDU ☐ Ward ☐ _____ Unknown ☐ _____
Insertion site:	R Hand ☐ R Arm ☑ R Foot ☐ L Hand ☐ L Arm ☐ L Foot ☐ Other: _____
Colour of cannula:	Blue ☐ Pink ☐ Green ☑ White ☐ Grey ☐ Orange ☐
Explanation and PVC leaflet provided to patient/ carer	Yes ☐ No ☐ If No, state reason: _____

PVC Maintenance Check	Does the Patient require this PVC for any of the DRIFT criteria? (Diagnostics, Resuscitation/ Chest Pain, IV Drugs, Fluids, Transfusion)	VIP score. (See Chart on back of care plan) If ≥ 2 remove PVC and record reason*.	Is the PVC dressing intact?	If PVC used for IV antibiotics can these be switched to oral? (See IVOST Flowchart on back of care plan)	Initial
Day 1 Check 1 Day ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 1 Check 2 Night ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 2 Check 1 Day ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 2 Check 2 Night ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 3 Check 1 Day ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 3 Check 2 Night ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	

A PVC device should only be kept in if the patient needs one for any of the reasons listed in DRIFT. Please also check the IVOST guideline re switching from IV to oral antibiotics. If there is a clinical reason for requiring the PVC for longer than 3 days, please document your reason here.

Date: ___/___/___ Reason for keeping PVC in after 72 hrs/ 3 days: _____

*Date PVC Removed: ___/___/___

*Reason For Removal: _____

Modified Visual Infusion Phlebitis (VIP) Score

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

DRIFT

Intravascular devices are associated with an increased risk of phlebitis, thrombosis, local infection and S. aureus bacteraemia. It is essential that you justify the need for your patient to have a PVC daily using the DRIFT mnemonic.

- ✓ **Diagnostics:** Does the patient need the cannula for a diagnostic procedure e.g. CT scan
- ✓ **Resuscitation:** Is the patient at risk of cardiac or respiratory arrest?
- ✓ **Intravenous:** Does the patient require IV medication? Could these be switched to oral?
- ✓ **Fluids:** Does the patient require intravenous fluids ? Could this be switched to oral fluids?
- ✓ **Transfusion:** Does the patient require a transfusion of blood products?

Adult IV → Oral Antibiotic Switch Therapy (IVOST) Guideline ➔ **Can I switch my patient from IV to oral antibiotics?**

Review need for IV antibiotics DAILY:
Review & document patient progress/the IVOST plan within 72 hours of antibiotic initiation

Are all of the following IVOST criteria met?

- ✓ **CLINICAL IMPROVEMENT** in signs of infection e.g. temperature ≤ 37.9°C, reduction in the NEWS score, improving SEPSIS
- ✓ **ORAL ROUTE** is available reliably (eating/drinking and no concerns regarding absorption)
- ✓ **UNCOMPLICATED INFECTION** (specialist advice not required prior to IVOST). Certain infections need prolonged IV, e.g. CNS infection, Cystic Fibrosis, S. aureus bacteraemia (min. 14 days IV), Endocarditis, Vascular graft or Bone/joint infection, Undrainable deep abcess

CRP does NOT reflect severity of illness or the need for IV antibiotics & may remain elevated as the infection improves

DO NOT use CRP in isolation to assess IVOST suitability. Most infections require 7 days TOTAL (IV + oral) therapy. Record the intended duration on the medicine kardex

YES

This patient may be suitable for switch to oral antibiotics. Please discuss with medical staff and refer to the full IVOST Guideline.

NO

1203893450
WEIR M
James 12/03/1989
27D MACDOWALL STREET
Johnstone, Renfrewshire
PA5 8QJ

4AT and TIME for Detection, Management and Prevention of Delirium

Complete for patients: age 65 and over; patients of any age with an existing cognitive impairment; previous delirium; current hip fracture; or severe illness. These patients are at high risk of delirium.

This should be done on admission; at each transition of care; if SQiD positive; or if any clinical concerns.

4AT					
(1) Alertness This includes patients who may be markedly drowsy (e.g. difficult to rouse and/or 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**	Ward ____ Date & Time	Ward ____ Date & Time	Ward ____ Date & Time	Ward ____ Date & Time	Ward ____ Date & Time
Normal (fully alert, but not agitated, throughout the assessment)	**0**	**0**	**0**	**0**	**0**
Mild sleepiness for <10 seconds after waking, then normal	**0**	**0**	**0**	**0**	**0**
Clearly abnormal	**4**	**4**	**4**	**4**	**4**
(2) AMT4 Ask the patient their **Age, Date of Birth, Place (name of hospital) Current Year**					
No mistakes	**0**	**0**	**0**	**0**	**0**
1 mistake	**1**	**1**	**1**	**1**	**1**
2 or more mistakes	**2**	**2**	**2**	**2**	**2**
(3) Attention Ask the patient **"Please tell me the months of the year in backward order, starting at December".** To assist, one prompt of **"What is the month before December"** is permitted.					
Achieves 7 months or more correctly	**0**	**0**	**0**	**0**	**0**
Starts but scores < 7 months or refuses to start	**1**	**1**	**1**	**1**	**1**
Untestable (cannot participate because too drowsy or inattentive)	**2**	**2**	**2**	**2**	**2**
(4) Acute change or fluctuating course Evidence of significant change or fluctuation in: alertness, cognition, other mental function (e.g. hallucinations, paranoia) over the past 2 weeks and still present in preceding 24 hrs.					
No	**0**	**0**	**0**	**0**	**0**
Yes	**4**	**4**	**4**	**4**	**4**
4AT TOTAL SCORE					
Print initials of assessor					

Score >4 This is a possible DELIRIUM +/- COGNITIVE IMPAIRMENT, start 'T' and 'I' of TIME and escalate to medical staff to confirm diagnosis	**Score 1-3** This is a possible COGNITIVE IMPAIRMENT, and requires further assessment	**Score 0** DELIRIUM or SEVERE COGNITIVE impairment unlikely

All patients scoring 0-3 are still at high risk of delirium. Use the Triggers listed overleaf to plan care and reassess daily by asking **'Is the patient more confused or drowsy?'** This is the single question in delirium (SQiD)

Affix ID Label

NHS Greater Glasgow and Clyde

TIME checklist to guide Delirium risk reduction, Identification and Management

The TIME checklist is a joint medical and nursing responsibility.

	Triggers, Investigate, Manage and Engage	Date	Date	Date	Date	Date
	Think possible triggers for delirium	Tick box	Tick box	Tick box	Tick box	Tick box
Triggers	**Is the patient in pain?** Start pain chart, review analgesia and consider need for an aperient					
	Is the patient constipated or at risk of constipation? Commence bowel chart and review daily to assess for constipation, especially if on analgesia. Consider rectal examination					
	Is the patient in urinary retention? Palpate bladder/scan					
	Is the patients oral intake sufficient to prevent dehydration? Encourage hourly fluids, start fluid balance chart					
	Could any drugs trigger delirium? Doctor to review medication					
	Blood sugar, high or low?					
	Is there a history of alcohol intake/drug abuse? Intoxication or withdrawal, start CMAWS/drug misuse guidelines					
	Does the patient have sensory impairment? Ensure patient is wearing their glasses/hearing aid(s)					
	Is the patient immobile? Promote early mobilisation in order to prevent delirium					
	Document 4AT score					
	Does the patient have Delirium? (Yes/No/Unsure) Please Circle	Y N U	Y N U	Y N U	Y N U	Y N U
Investigate	**Investigate**					
	Record NEWS					
	Screen for infection					
	Take bloods and ensure ECG/appropriate imaging					
Manage	**Management: Diagnose causes & initiate treatment**					
	Document diagnosis of delirium					
	Document potential causes of delirium					
	Document treatment plan					
Engage	**Engage and Explore**					
	If appropriate, explain diagnosis of delirium to patient/ family/ carers and provide delirium leaflet					
	Engage with patient/ family/ carers. Complete "What matters to me"/"Getting to know me" document					
	Does the patient have capacity to consent to care? (Yes/No/Ongoing Assessment)	Y N O	Y N O	Y N O	Y N O	Y N O
	If no, complete AWI document					
	Print initials of assessor					

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Glasgow Assessment and Management of Alcohol

NHS Greater Glasgow and Clyde

Please Attach Patient Label

CHI: 1203893450

Name: WEIR James M

Address: 27D MACDOWALL STREET 12/03/1989
Johnstone, Renfrewshire
PA5 8QJ

Postcode:

Alcohol By Volume (ABV%)	Average Units (ABV% x Vol)
Strong Lager 9% (440mls)	4.0 Units
Beer/ Lager 4.5% (Pint/500mls Can/Bottle)	2.2 Units
Wine (e.g.Buckfast) 15% (750mls)	11.0 Units
Wine (Table) 12% (750mls)	9.0 Units
Wine (Table) 12% (175ml glass)	2.1 Units
Alcopops 5% (330mls)	1.5 Units
Spirits 40% (25ml measure)	1.0 Unit
Spirits 40% (¼ bottle 175mls)	7.0 Units
Spirits 40% (Litre)	40.0 Units
Spirits 40% (700mls)	30.0 Units
Cider 4% (Litre)	4.0 Units
Cider 4% (440mls)	1.8 Units
Strong White Cider 8% (Litre)	8.0 Units
Strong White Cider 8% (300ml glass)	2.4 Units

Number of Units = ABV (%) x Volume (litres) 20-30 units per day

eg A bottle of wine (750mls) which is 12% ABV = 12 x 0.75 = 9 Units
A glass of wine (200mls) which is 12% ABV = 12 x 0.2 = 2.4 Units

Estimated Weekly Alcohol Units :
(Daily Units x Number of Days per Week)

Excessive Weekly Consumption
(♂: >21 units/week; ♀: >14 units/week)

Estimated Date / Time Of Last Drink 10/6/20 14:45 (If ≥ 5 Days, Re-consider Alcohol Withdrawal Status)

Presents With (or has Previous History of) Alcohol Related Seizures Yes ☑ No ☐

Presents With (or has Previous History of) Severe Alcohol Withdrawal Yes ☐ No ☑

Fast Alcohol Screening Tool - FAST:

Note : 1 drink = 1 unit of alcohol (refer to table above)

1. MEN: How often do you have EIGHT or more drinks on one occasion?
   WOMEN: How often do you have SIX or more drinks on one occasion?

   Never ☐0 Less than monthly ☐1 Monthly ☐2 Weekly ☐3 Daily or almost daily ☑4

2. How often during the last year have you been unable to remember what happened the night before because you had been drinking?

   Never ☐0 Less than monthly ☐1 Monthly ☐2 Weekly ☐3 Daily or almost daily ☑4

3. How often during the last year have you failed to do what was normally expected of you because of drinking?

   Never ☐0 Less than monthly ☐1 Monthly ☐2 Weekly ☐3 Daily or almost daily ☑4

4. In the last year has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down?

   No ☐0 Yes, on one occasion ☐2 Yes, on more than one occasion ☑4

Score of 3 or more: FAST Positive

Total 16

FAST Positive?

Yes ☑ No ☐

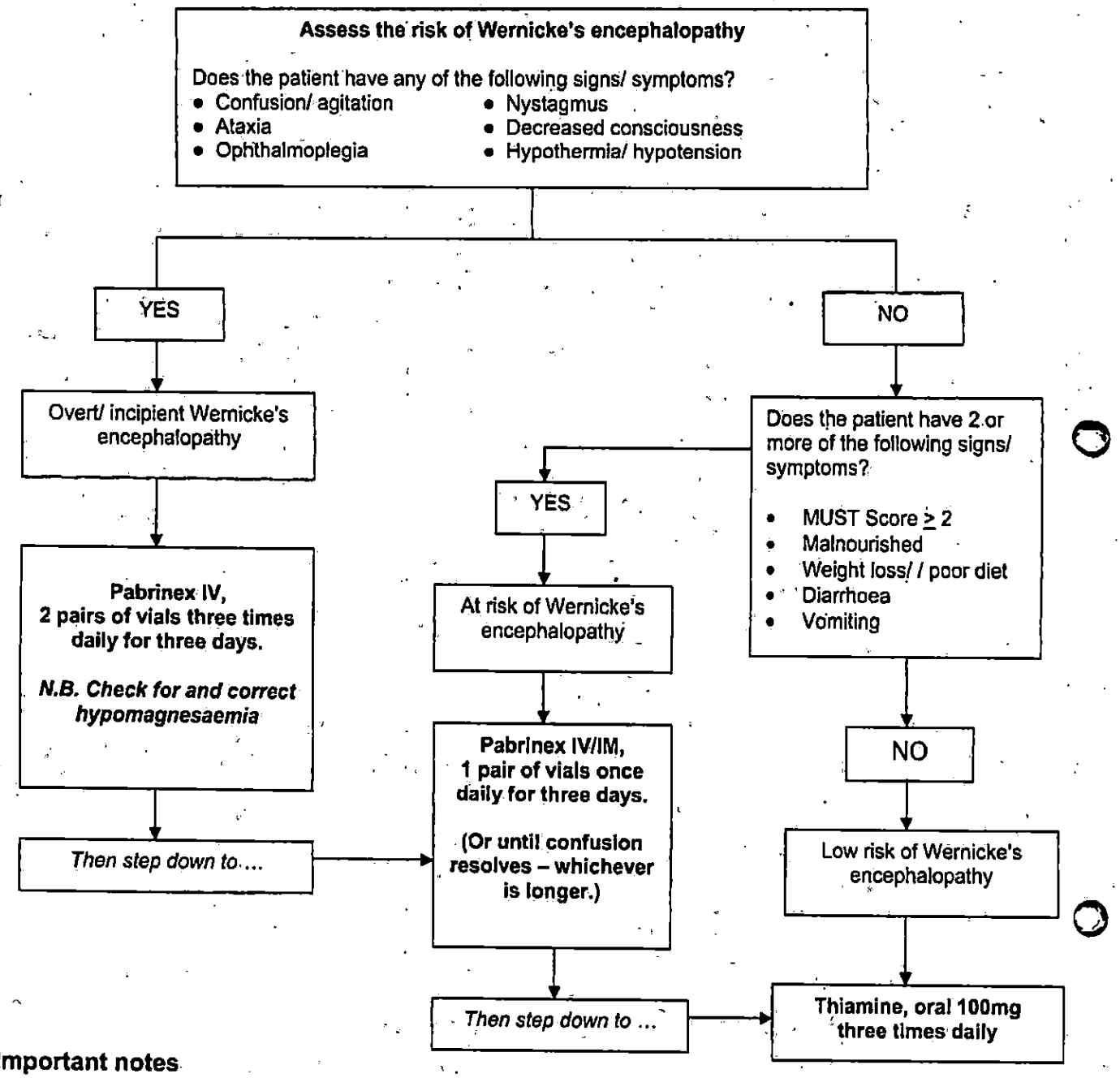
FAST 0-2:	Negative: No action required.
FAST 3-8:	Hazardous Drinking: Advise regarding safe drinking levels and offer information leaflet / advice.
FAST 9-16:	Probable Dependent Drinking: Advice as above and consider referral to Addiction Liaison Service.

PLEASE INSERT IN PATIENT'S CASE RECORD ON COMPLETION OF TREATMENT

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Vitamin Prophylaxis and Treatment of Wernicke-Korsakoff Encephalopathy

The guidance applies to patients who are chronic alcohol abusers. This includes those who are dependent on alcohol but also those who have a hazardous/ harmful alcohol intake.



Important notes

- Patients with overt/ incipient Wernicke's encephalopathy or 'at risk' of Wernicke's encephalopathy **must** be given Pabrinex® **before** the administration of glucose or nutritional support.
- Intravenous Parbinex® should be administered over 30 minutes
- Anaphylaxis is a rare complication of IV Pabrinex® administration and even more uncommon with IM administration. Monitor patient for wheeze, tachycardia, breathlessness and skin rash. Facilities for the administration of adrenaline and other resuscitation should be available
- Further vitamin supplementation as clinically indicated by responsible medical team in the context of a general nutritional assessment

Management of Alcohol Withdrawal Syndrome

DEPENDENT DRINKING ON SCREENING - HIGH RISK

Any 2 of the following:

- Presents with or has had previous withdrawal seizures
- Previous severely agitated withdrawal (D.T.'s)
- High screening score (FAST >12)
- High initial symptom score (GMAWS >8)

YES

FIXED DOSE DIAZEPAM
PLUS
SYMPTOM TRIGGERED TREATMENT

Have you considered exceptional patient groups

NO

SYMPTOM TRIGGERED TREATMENT

Have you considered exceptional patient groups

BASELINE TREATMENT REGIME

Fixed Dose oral Diazepam: (for patients unable to tolerate diazepam via the oral route, see below).

Initial 24 hours: **20mg Diazepam 6 hourly**

If no additional symptom triggered treatment, then REDUCE as follows:

- 15mg Diazepam 6 hourly for 24 hours
- 10mg Diazepam 6 hourly for 24 hours
- 5mg Diazepam 6 hourly for 24 hours
- 5mg Diazepam 12 hourly for 24 hours

Diazepam prescription to be reviewed if patient excessively drowsy.
Maximum of 120mg Diazepam in 24 hours, before requesting senior medical review.
(*Diazepam 120mg not expected to be problematic over 24hrs in uncomplicated patients).

EXCEPTIONAL PATIENT GROUPS:

- Elderly patients
- Head injury
- Patients with evidence of liver disease: especially jaundice, encephalopathy
- Patients with other significant co-morbidity (i.e. COPD, pneumonia, cerebrovascular disease, reduced GCS)

Consider the use of oral Lorazepam in these exceptional patient groups in a symptom triggered fashion: 1-2 mg (to a maximum of 12mg in 24 hours before requesting senior medical review).
Note: Lorazepam has a slower onset of peak effect but ultimately has a more rapid elimination

SEVERE WITHDRAWAL (aggressive/ uncontrollable/ dangerous behaviour)

- Intravenous diazemuls up to 40mg over first 30 minutes (up to 2mg/minute; flumazanil to be available)
- Adjunctive therapy with Haloperidol 5-10mg IV or IM (smaller doses unlikely to be effective)

PATIENTS UNABLE TO TOLERATE ORAL MEDICATION

- Patients unable to tolerate oral medication may receive intravenous therapy (diazemuls or lorazepam) as an alternative at 50% of the oral dose in the first instance, and response assessed

INTRAVENOUS BENZODIAZEPINES

- It is recommended that intravenous benzodiazepines are administered by an experienced member of medical staff (FY2 or above)
- If nursing staff administer intravenous benzodiazepines they MUST have completed the appropriate Competency Training to administer IV sedation

MONITORING

- All patients should be closely observed for signs of over-sedation with regular observations
- Exceptional Patient Groups (see above), patients with Severe Withdrawal and patients requiring Intravenous or Intramuscular Sedation require close monitoring (NEWS) ideally with one-to-one nursing care
- Consultation regarding intensive care support may be necessary in extreme situations

APPROXIMATE ORAL BENZODIAZEPINE EQUIVALENCE

10mg Diazepam = 1mg Lorazepam = 30mg Chlordiazepoxide

Patients should not be discharged on regular benzodiazepine unless there is a confirmed arrangement with the Community Addiction Services. Chlordiazepoxide is the recommended benzodiazepine for community use.

Glasgow Modified Alcohol Withdrawal Scale (GMAWS) **Treatment Option:** GMAWS Only ☐ GMAWS & Fixed Dose ☑

Date	10/6/20		1905	2030															
Time	1605	1800	10/6/20		2230														
Tremor 0) No tremor 1) On movement 2) At rest	1	0	0	0	0														
Sweating 0) No sweat visible 1) Moist 2) Drenching sweats	1	0	0	0	0														
Hallucination 0) Not present 1) Dissuadable 2) Not dissuadable	0	0	0	0	0														
Orientation 0) Orientated 1) Vague, detached 2) Disorientated, no contact	0	0	0	0	0														
Agitation 0) Calm 1) Anxious 2) Panicky	2	0	0	0	0														
Score	4	0	0	0	0														
Treatment	20mg	Nil	NIL	20mg Lorazepam Medication intolerance	Nil														
Staff Signature		LW	GS	SJ	SJ														

Score: (Do not use scoring tool if patient intoxicated, must be at least 8 hours since last drink.)

0 : Repeat Score in 2 hours (Discontinue after scoring on 4 consecutive occasions, except if less than 48hrs after last drink)

1 – 3 : Give 10mg Diazepam: Repeat Score in 2 hours

4 – 8 : Give 20mg Diazepam : Repeat Score in 1 hour

9 - 10 : Give 20mg Diazepam : Repeat Score in 1 hour, and discuss with medical staff regarding management of severe withdrawal as per guideline (see page 3)

PATIENTS MAY REQUIRE TO BE WOKEN FOR CONTINUING ASSESSMENT

CO-EXISTING ILLNESS MAY AFFECT SCORE: SEEK MEDICAL ADVICE IF IN DOUBT

FIXED DOSING & SYMPTOM TRIGGERED DOSING MUST BE NO LESS THAN 1 HOUR APART

All patients should have regular observations documented. Patients receiving high doses of Diazepam should be assessed regularly for over sedation. Regular NEWS – Frequency 1-4hrs. (GCS, Respiration rate. Oxygen sat^{n}, Pulse, Blood Pressure)

Developed by the Acute Alcohol Screening & Withdrawal Management Guideline Group
Chaired by Dr Ewan Forrest, Consultant Physician and Gastroenterologist, GRI

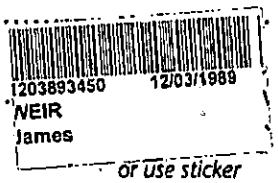
Published April 2011
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Version 4

Patient name .....

Patient CHI



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Emergency Care Nursing Documentation

Presenting complaint - and relevant past medical history including allergies

Date and Time		Name/Signature
10.06.20	~~ALLERGY TO PENICILLINS~~	
15:40hrs	Alcohol withdrawal	A hyle (HCSW)

Nursing notes - on admission

Date and Time		Name/Signature
10.06.20	Patient into room,	
15:40hrs	awaits A&E review	A hyle (HCSW)
	GMAWS ☑	
	Active care ☑	AP
16.00	20mg diazepam given	
	as per prescription	AP

Triage

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

Communication

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

Risk Assessments and Screening Tools

SEPSIS	Y	(N)	GMAWS	(Y)	N
FAST	Y	(N)	Adult Support and Protection	Y	(N)
Swallow Testing	Y	(N)	Mental Health Triage Assessment	Y	(N)
Falls Risk (clinical judgeument)	Y	(N)	Child Protection Concerns	Y	(N)

Signature: AP

Patient name

Patient CHI

1203893450
WEIR M
James 12/03/1986
27D MACDOWALL STREET
Johnstone, Renfrewshire
PA5 8QJ

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Care Rounds Checklist

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

Signed AM Name AMcFadden Designation HCSW

Signed _____ Name _____ Designation _____

Signed _____ Name _____ Designation _____

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

			Times	1600	1800									
	1	**THINK DELIRIUM** Is the patient more confused/drowsy than normal? If yes inform registered nurse.		N	N									
	2	**PAIN: ASSESS AND ADDRESS.** Is the patient distressed or in pain? If yes inform registered nurse.		Y	No									
S	3	**SKIN INSPECTION** Pressure areas checked?		N	No									
		R = RED **D** = Discloured **PU** - Pressure Ulcer **INT** = Intact **M**= Moisture		I	Int									
K	4	**KEEP MOVING** Has the patient moved or walked?		Y	Y									
		Bed **R** =Right side (30°) tilt **L** =Left side (30°) tilt **B** =Back Chair **W/ST** = Assist to walk / stand		B	B									
		ELIMINATION. Does the patient need the toilet?		N	N									
I	5	**I** = Independent **A** - Assistance given **IC** = Incontinent (urine/faeces)		I	I									
N	6	**FOOD FLUIDS AND NUTRITIO.** Is the patient nil by mouth?		N	EtO									
		Drink taken?		Y	Y									
		Food, snack, or supplements taken?		N	No									
		Has oral hygiene been carried out as per care plan?		N	No									
	7	**ENVIRONMENT CHECK** Is the patient's call buzzer to hand? Is the area clutter free clean and safe? Does the patient have everything they require in safe reach? Is the bed in the lowest position?		Y	✓									
	8	**INFORMATION** Is there anything else I can help you with? Inform the patient of the time of return		Y	✓									
	9	**ESCALATION** Is there anything else I can help you with? Inform the patient of the time of return		Y	✓									
		Care provider		AM	AM									
		Role		HCSW	N									

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

Patient nar

Patient CHI

1203893450
WEIR M
James 12/03/1989
27D MACDOWALL STREET
Johnstone, Renfrewshire
PA5 8QJ

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

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PUDRA

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

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

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

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

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

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

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

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

Patient name

Patient CHI

1203893450
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James M
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PA5 8QJ

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Nursing notes - discharge plannning

Date and Time		Name/Signature

Outcomes and outstanding issues

Date and Time		Name/Signature

Pause for Discharge or Transfer

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

Contact with relatives

Signature:

Patient name

Patient CHI

1203893450
WEIR M
James 12/03/1989
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Johnstone, Renfrewshire
PA5 8QJ

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4AT assessment - for delirium and cognitive impairment

		Circle Score
(1) ALERTNESS This includes patients who may be markedly drowsy (eg. dificult 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 (alert, but not agitated, through assessment) Mild sleepiness (<10 secs) after waking, then normal Clearly abnormal	0 0 4
(2) AMT4 Age, date of birth, place (name of the hospital/building), current year.	No mistakes 1 mistake 2 or more mistakes/untestable	0 1 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.	wAchieves 7 months or more correctly Starts but scores <7 months / refuses to start Untestable (cannot start, unwell, drowsy, inattentive	0 1 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 Yes	0 4

4 or more possible delirium + /- cognitive impairment
1-3 possible cognitive impairment
0 delirium or severe cognitive impairment unlikey (but delirium still possibe if (4) information incomplete

TOTAL

Frailty Assessment Tool (Healthcare Improvement Scotland)

Step 1 Would this person benefit from Comprehensive Geriatric Assessment (CGA)? circle Y or N

F	**Functional impairment**	(new or worsening) eg difficulty with self care	**Y**	**N**
R	**Resident**	in a care home	**Y**	**N**
A	**Altered mental state**	such as delirium or dementia **(4AT Assessment)**	**Y**	**N**
I	**Immobility/Instability**	decline in mobility, difficulty mobilising without help, fall leading to presentation	**Y**	**N**
L	**Living at home with support**	on a daily basis (homecare, one visit or more per day)	**Y**	**N**

If YES to any of the criteria in Step 1 move to Step 2

Step 2 Would this person be better managed by another speciality team at present? circle Y or N

Clear need for other specialty input eg exacerbation of known long-term condition such as COPD	**Y**	**N**
Need for HDU/ITU (including non-invasive ventilation)	**Y**	**N**
Suspected new stroke or TIA, consider thrombolysis and care in stroke unit	**Y**	**N**
Head injury with loss of consciousness	**Y**	**N**
Acute abdominal pain/ surgical presentation	**Y**	**N**
Upper GI Bleed	**Y**	**N**
Chest pain with suspected acute coronary syndrome	**Y**	**N**
Trauma with suspected fracture	**Y**	**N**

Are any of the criteria met?

If YES to any criteria in Step 2: Prioritise move to non geriatric service as appropriate. If necessary consider geriatric advice on parent ward.

If YES to any criteria in Step 1 and NO to ALL criteria in STEP 2: Prioritise transfer of care to specialist geriatric assessment service.

Patient name

Patient CHI

1203893450
WEIR M
James 12/03/1989
27D MACDOWALL STREET
Johnstone, Renfrewshire
PA5 8QJ

NHS
Greater Glasgow and Clyde

Nursing notes - ongoing care

Date and Time		Name/Signature
19/6/20 17:00	IV Paracetamol commenced	
18:00pm	Pt transfer wants to go home. Remains Vitally Stable GCS 15/15	
	Scoring 0 on GMAWS.	
18:35pm	Pt for TTF to MAU.	

NEWS – National Early Warning Score

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Name
Address



CHI No.
DoB

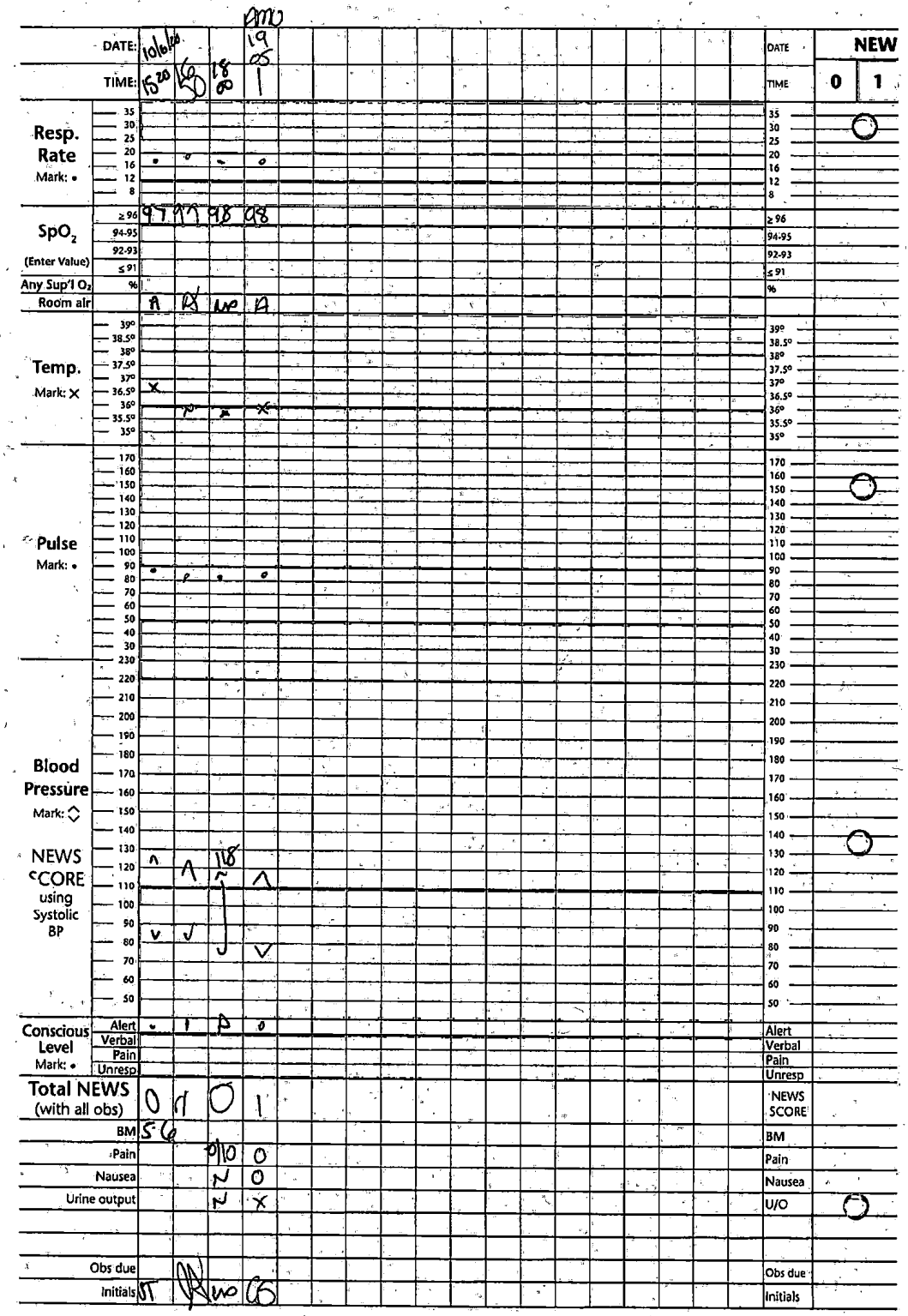
	Date	Ward
Admitted		
Transferred		
Transferred		

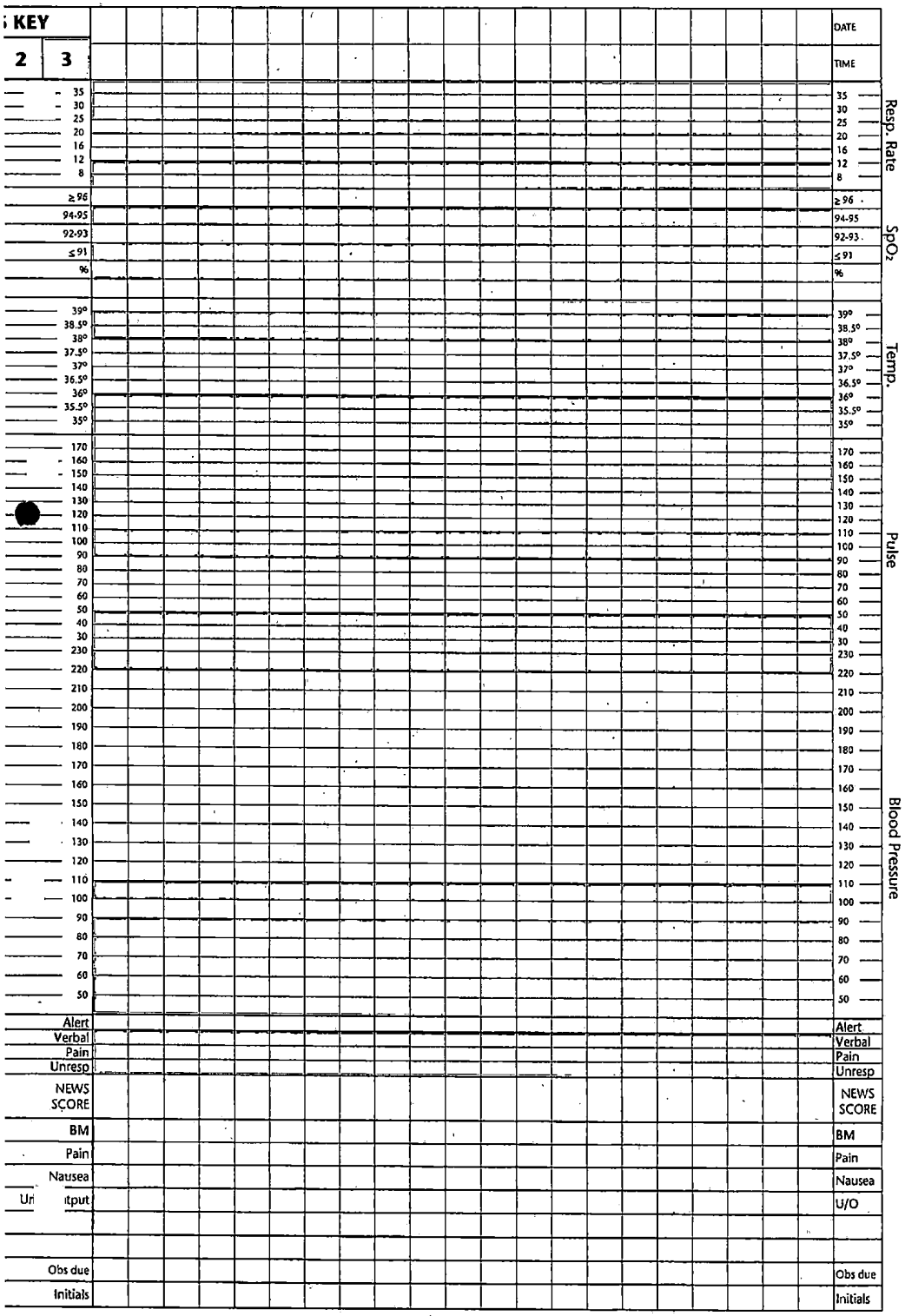
Physiological Parameter	NEWS – NHS Early Warning Score						
	3	2	1	0	1	2	3
Respiration Rate	≤8		9-11	12-20		21-24	≥25
Oxygen Saturations	≤91	92-93	94-95	≥96			
Any Supplemental Oxygen		Yes		No			
Temperature	≤35.0°		35.1-36.0°	36.1-38.0°	38.1-39°	≥39.1°	
Pulse	≤40		41-50	51-90	91-110	111-130	≥131
Systolic BP	≤90	91-100	101-110	111-219			≥220
Conscious Level				A			V, P or U

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

See NEWS Actions Reference Tool for local escalation policy

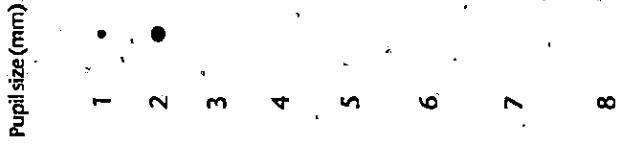
NEWS Score	Frequency of Monitoring	Clinical Response
0	Minimum 12 hourly	• Continue routine NEWS monitoring with every set of observations.
Aggregate 1- 4	Minimum 4 hourly	• Inform trained nurse. • Trained Nurse assessment: - Assess the patient - Review frequency of monitoring required - Assess need for escalation of clinical care and direct as appropriate.
Aggregate 5 or more or 3 in one parameter	Increased frequency to a minimum of 1 hourly	• Trained Nurse assessment. • Inform medical team caring for the patient. • Urgent assessment by a medical / surgical / nursing team with core competencies to assess acutely ill patients. • Consider level of monitoring required in relation to clinical care.
Aggregate 7 or more	Continuous monitoring of vital signs	• Trained Nurse to assess immediately. • Inform medical team caring for the patient – this should be at least senior medical staff level. • Emergency assessment by a clinical team with core competencies in the assessment of critically ill patients. This team will have critical care competencies and a practitioner/s with advanced airway skills and resuscitation skills. • Consider referral to high dependency or ITU.


DATE:
TIME:
Resp. Rate
Mark: •
SpO2
(Enter Value)
Any Sup'l O2
Room air
Temp.
Mark: ×
Pulse
Mark: •
Blood Pressure
Mark: ◇
NEWS SCORE using Systolic BP
Conscious Level
Mark: •
Alert
Verbal
Pain
Unresp
Total NEWS (with all obs)
BM
Pain
Nausea
Urine output
Obs due
Initials
NEW
0
1


KEY
2
3
DATE
TIME
Resp. Rate
35
30
25
20
16
12
8
SpO2
≥ 96
94-95
92-93
≤ 91
%
Temp.
39°
38.5°
38°
37.5°
37°
36.5°
36°
35.5°
35°
Pulse
170
160
150
140
130
120
110
100
90
80
70
60
50
40
30
Blood Pressure
230
220
210
200
190
180
170
160
150
140
130
120
110
100
90
80
70
60
50
Alert
Verbal
Pain
Unresp
NEWS SCORE
BM
Pain
Nausea
U/O
Obs due
Initials

Glasgow Coma Scale

Pupil size (mm)



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27D MACDOWALL STREET 12/03/1989
Johnstone, Renfrewshire
PA5 8QJ

Neurological Observations

Date:				10/3																								
Time:				1800																								
COMA SCALE	E Eyes open	Spontaneously	4	4																								Eyes closed by swelling = C
		To speech	3																									
		To pain	2																									
		None	1																									
	V Best Verbal response	Orientated	5	5																								Endotracheal tube or tracheostomy = T
		Confused	4																									
		Inappropriate words	3																									
		Incomprehensible sounds	2																									
		None	1																									
	M Best motor response	Obeys	6	6																								Usually record the best arm response
		Localises	5																									
		Flexion - withdrawal	4																									
		Flexion - abnormal	3																									
		Extension to pain	2																									
		None	1																									
	TOTAL SCORE			15																								
PUPILS	R	Size		3																								+ reacts – no reaction c. eyes closed
		Reaction		1																								
	L	Size		3																								
		Reaction		1																								
LIMB MOVEMENT	ARMS	Normal power		WNL																								Record right (R) and left (L) separately if there is a difference between the two sides
		Mild weakness																										
		Severe weakness																										
		Spastic flexion																										
		Extension																										
		No response																										
	LEGS	Normal power		WNL																								
		Mild weakness																										
		Severe weakness																										
		Spastic flexion																										
		Extension																										
		No response																										

Pain Score

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

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

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

Management Plan and Patient Exclusions

Date and Time	Notes	Signed

Acute Services Division

Nursing Admission & Assessment

1. Admission

NHS Greater Glasgow and Clyde

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Johnstone, Renfrewshire
PA5 8QJ

Hospital: RAH	Ward: AMU
Date of admission: 11/8/15	Time: 0200
Admitting Consultant:	Admitting Nurse: Charles
Expected date of discharge: / /	

1. Patient Details

Preferred name: James	Next of Kin (NoK): Debbie
Age: 27 years	Relationship: Sister
Religion: NA	NoK Address:
Telephone:	
GP: Dr. EC Renwick Quarryside Practice Linden Medical Centre 25 Floors Street Johnstone PA5 8PZ	NoK Telephone:
GP address:	NoK Aware of admission: ☐ Yes ☑ No
	Consent for information to be given to relatives: ☑ Yes ☐ No Nominated family contact: Telephone - Day: Telephone - Evening:
GP telephone:	

Is the patient a carer? ☐ Yes ☐ No If 'Yes' refer to Duty Social Worker if required: ☐ Referred ☐ Not required

Does the patient have an appointed Welfare Guardian / Power of Attorney? ☐ Yes ☐ No ☐ N/A

a. If 'Yes' please provide – Name: ..... Relationship: .....

Contact telephone number: .....

b. If 'Yes' does the patient have an 'Adult with Incapacity Section 47' certificate in place? ☐ Yes ☐ No ☐

If 'No' to 'b' please inform medical staff. Name of doctor informed: .....

2. Presenting Complaint / Diagnosis

Collapse.

Why does the patient think they are in hospital? *Use patients own words:*

3. Allergies (including food allergies)

No known allergies: ☑

4. Observations

Cannard	Waterlow	MUST	Pulse	BP	Resp	SaO_2	Temp
3	7	0	99.	118/72	15	96%	36.4

Urinalysis:	AMT4 Score	BM (AM-E)	NEWS Score	Weight Estimated / Actual	Height Estimated / Actual	BMI
	✓	5.6	0	?10st	5ft 10½	

5. Current Medication

Medicines reconciled on admission? ☐ Yes ☐ No

6. Relevant Past Medical History

mental Health issues.
Pancreatitis.
Gastritis.
Previous

7. Risk Assessment

MUST

1. Is the patient's BMI:
   - > 20 ..... Score 0
   - 18.5-20 ..... Score 1
   - <18.5 ..... Score 2

   Score 0
2. Has the patient had unplanned weight loss in the past 3-6 months?
   - < 5% ..... Score 0
   - 5-10% ..... Score 1
   - >10% ..... Score 2

   Score 0
3. If the patient is acutely unwell and there has been or is likely to be no food intake for > 5 days:
   - Score = 2
   - Not applicable: Score = 0

   Score 0

MUST Score: 0

If score 1 or more, complete full Nutrition Profile

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Affix patient data label

8. Cognitive Impairment

For all patients ≥ 65 years, ask the following 4 AMT questions:

1. How old are you? ..... years
2. What is your date of birth? / /
3. What is this place? .....
4. What year is it? .....

If the patient does not answer all questions correctly then refer to medical staff.

AMT Score: ..... out of 4

Name of Doctor informed (if required)

..... Grade .....

9. MRSA Screening / CJD / Healthcare outside Scotland

Will the patient be an inpatient >23 hours? ☐ Yes ☐ No If 'Yes' complete the following section.

1. Has the patient ever had a previous positive MRSA result? ☐ Yes ☑ No ☐ Not known
2. Has the patient been admitted from a Care Home/ institutional setting or another hospital? ☐ Yes ☑ No ☐ Not known
3. Does the patient have a wound / ulcer or invasive device which was present prior to this admission? ☐ Yes ☑ No ☐ Not known

If **'Yes'** to any of the above questions **OR** if the patient is admitted to a 'high impact speciality' e.g. **Orthopaedics, Vascular, Renal Unit, Critical Care – then obtain MRSA Swabs:**

☐ **Nasal** ☐ **Perineum** ☐ **Other - Specify:** ☐ **Patient refused**

CJD: Has the patient ever been contacted by Public Health and told that they are possibly at risk of CJD:

☐ Yes ☐ No If 'Yes' contact Infection Control Team. Infection Control Team contacted: ☐

Healthcare outside Scotland

Has the patient been transferred from, or received health care in, a hospital outside of Scotland in the last 12 months:

☐ Yes ☐ No If 'Yes obtain rectal swab and send to microbiologty for CPE screen.

Rectal swab taken ☐ Patient refused ☐

10. Lifestyle

Smoking:

Does the patient smoke? ☐ Yes ☑ No

If 'Yes' how many per day:

Does the patient use nicotine replacement therapy? ☐ Yes ☐ No

Does the patient wish referral to Smoking Cessation Service?

☐ Yes ☐ No If 'Yes', date of referral: / /

Drugs: Does the patient use recreational drugs? ☐ Yes ☑ No If 'Yes' specify:

Alcohol (Men): How often do you have **8** or more drinks on one occasion:

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

If 'Monthly' or more then complete FAST Tool.

Alcohol (Women): How often do you have **6** or more drinks on one occasion:

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

If 'Monthly' or more then complete FAST Tool.

11. Admission Documentation Completed By

Name (Please PRINT): Ewan C	Signature:
Designation: SN	Date: 11/8/15

Acute Services Division

Nursing Admission & Assessment

2. Assessment

Hospital: RAH	Ward: AMU
Date of Assessment: 11/8/15	Time: 0200

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1. Breathing and Circulation

Breathing:

- [x] No symptoms or history of respiratory problems
- [ ] Dyspnoeic at rest
- [ ] Dyspnoeic on minimal exertion
- [ ] Dyspnoeic on maximum exertion
- [ ] Productive / non-productive cough evident
- [ ] Normally receives oxygen therapy

If 'Yes' provide details:

Circulation:

- [x] No symptoms
- [ ] Known cardiac or circulatory problems

Problem identified: [ ] Yes [ ] No If 'Yes' please describe

	Initial

2. Communication

Assessment of ability to communicate:

What language does the patient speak?:

English

Interpreter: Required [ ] Not required [x]

If required, provide details and arrangement made:

.....

.....

Does the patient have:

a. Speech difficulties? [ ] Yes [x] No

b. A learning disability e.g. Down's Syndrome?

[ ] Yes [x] No

If 'Yes' please specify:

.....

If 'Yes' contact Liaison Learning Disability Team.

Liaison Learning Disability Team contacted:

[ ] Yes [x] No

c. A learning difficulty e.g. dyslexia, dyspraxia?

[ ] Yes [x] No

If 'Yes' please specify:

.....

3. Senses

Senses:

Eyesight

- [x] Normal vision
- [ ] Glasses – [ ] Distance [ ] Reading
- [ ] Prosthesis – [ ] Left [ ] Right
- [ ] Contact lenses
- [ ] Registered blind

Hearing

- [x] Normal
- [ ] Hearing impaired
- [ ] Hearing aid – [ ] Left [ ] Right

4. Mental Status

Mental Status:

- [x] Orientated
- [ ] Confused
- [ ] Distressed
- [ ] Aggressive /Abusive
- [ ] Unconcious

Problem identified: [ ] Yes [ ] No If 'Yes' please describe

	Initial

5. Hydration and Nutrition

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MUST Score: ..... **If score is 1 or more, complete a Nutrition Profile.**

Nutition Profile completed ☐ Yes ☐ No
If 'Yes' do not complete sections 5a to 5d.

- **If score is 0, reassess / screen patient in 7 days.**
- **Complete sections 5a to 5d.**

Date of reassessment: / /

5a 1. Food likes / dislikes:

Not Risky

5a 2. Fluid likes / dislikes:

Not Risky

5c. Help needed with eating and drinking:
☐ Yes ☑ No
If 'Yes' provide details:

5b. Cultural or religious diet needed (e.g. vegetarian, vegan, halal, kosher etc):
☐ Yes ☑ No
If 'Yes' specify diet needed:

5d. Texture Modified Diet needed?
☐ Yes ☑ No
If 'Yes' specify texture: A☐ B☐ C☐ D☐ E☐
Thickened Fluids required? ☐ Yes ☐ No
If 'Yes' specify stage required: 1☐ 2☐ 3☐

Problem identified: ☐ Yes ☐ No If 'Yes' please describe

	Initial

6. Elimination

Continent:	Incontinent:	NHS GGC Stool Chart commenced:
☑ Bladder	☐ Bladder	☐ Required ☑ Not required
☑ Bowel	☐ Bowel	

Long-term urinary catheter in situ? ☐ Yes ☑ No If 'Yes' – Size: .....fg Make: .....
Date catheter last changed: / /

Continence assessment commenced:	Containment products in use? Please specify:
☐ Yes ☐ No ☑ Not applicable	
☑ Bowels regular ☐ Constipated ☐ Diarrhoea / loose stools	Stoma: ☐ Yes ☑ No If 'Yes' please specify and list appliances used:

Problem identified: ☐ Yes ☐ No If 'Yes' please describe

	Initial

7. Personal Hygiene, Oral Health and Skin Assessment

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Personal hygiene:

☑ Self-caring and independent
☐ Requires assistance

Specify assistance if required:

Oral health:

Self-caring and independent	☑ Yes	☐ No
Does the the patient have a sore mouth	☐ Yes	☑ No
Does the patient have a non healing mouth ulcer	☐ Yes	☑ No

If the patient has a sore mouth or non healing mouth ulcer, refer to dentist (See StaffNet for dentist referral pathway) and implement Oral Care Bundle.

Oral Hygiene Care Bundle:

☐ Required ☑ Not required

Dentures:

☑ Not worn
☐ Upper set
☐ Lower set
☐ Full set
☐ Dentures with patient on admission

Skin assessment:

☑ Skin healthy with no evidence of damage
☐ Skin broken ☐ Skin oedematous ☐ Skin discoloured ☐ Skin clammy

If 'Yes' to any of the above, describe skin condition:

Wound Assessment Chart completed: ☐ Yes ☑ No ☐ Not applicable

Pressure ulcer evident: ☐ Yes ☑ No

If 'Yes' please identify Grade and record on Pressure Ulcer record sheet – Grade: .....

Problem identified: ☐ Yes ☐ No If 'Yes' please describe

Initial

8. Mobility

Patient fully mobile / independent? ☑ Yes ☐ No If 'No' complete Moving and Handling Assessment.

☐ Limited mobility

☐ Mobile with aid – Specify:

☐ Prosthesis – Specify:

Moving and Handling Plan commenced:

☐ Yes ☑ No

Problem identified: ☐ Yes ☐ No If 'Yes' please describe

Initial

9. Maintaining a Safe Environment

Pain status:

Does the patient have pain? ☐ Yes ☑ No

If 'Yes' record Pain Score on NEWS chart.

What makes their pain better? Please provide brief details:

Bed rail assessment completed: ☐ Yes ☑ No

Bed rails required:

☐ Required ☑ Not required

Problem identified: ☐ Yes ☐ No If 'Yes' please describe

Initial

10 Sleep and Rest

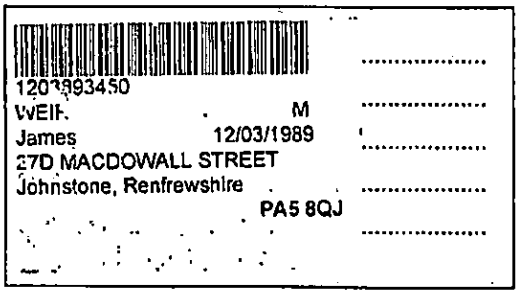
Sleep habits:

- [x] Less than 8 hours
- [ ] Afternoon nap
- [ ] Morning nap

Sleep difficulties:

- [x] None
- [ ] Disturbed e.g. nocturia, insomnia
- [ ] Early wakening

Medication required: [ ] Yes [x] No



Problem identified: [ ] Yes [ ] No If 'Yes' please describe

	Initial

11 Social Circumstances

- [x] Employed [ ] Unemployed [ ] Retired
- [x] Lives alone
- [ ] Lives with Family
- [ ] Friend
- [ ] Dependants
- [ ] Other: [ ] Nursing Home [ ] Residential

Current Care / Support arrangements:

- [ ] Social Services [ ] Unpaid carer e.g. family, friends
- [ ] Private Carers [x] None

If support services in place, please provide details:

Problem identified: [ ] Yes [ ] No If 'Yes' please describe

	Initial

12 Privacy, Dignity and Sexuality

Does the patient have issues related to privacy, dignity and/or sexuality that are relevant to admission?

[ ] Yes [ ] No

If 'Yes' please provide brief details:

13. Spiritual Care

Is there anything with regard to faith or culture that we can support the patient with during their stay in hospital (e.g. prayer, meditation)?

[ ] Yes [ ] No

If 'Yes' please provide brief details:

Is there anything causing the patient a lot of anxiety at the time of admission that staff should be aware of?

[ ] Yes [ ] No

If 'Yes' please provide brief details:

Ask the patient:

"Would you like the ward staff to arrange for a Hospital Chaplain to visit you while in hospital?"

[ ] Yes [ ] No [ ] Not at this time

If 'Yes' please specify faith group:

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14. Anticipatory Care

(This section is for patients thought to be in the last year of life, where appropriate and relevant)

Appropriate ☐ Not appropriate ☐

Is the **patient** aware of their:
Diagnosis? ☐ Yes ☐ No
Prognosis? ☐ Yes ☐ No

Is the **patient's family** aware of their:
Diagnosis? ☐ Yes ☐ No
Prognosis? ☐ Yes ☐ No

Preferred place of care:
Home: ☐ Hospital ☐ Hospice ☐

Preferred place of death:
Home: ☐ Hospital ☐ Hospice ☐

Current treatment – please identify (e.g. chemotherapy/ radiotherapy):

Other agencies involved in patient's care – please identify (e.g.) Marie Curie, MacMillan Nurses):

DNACPR order in place: ☐ Yes ☐ No
If 'Yes' are the patient's family and next of kin aware? ☐ Yes ☐ No

15. Admission Assessment Completed By

Name (Please PRINT): [illegible]

Signature: [illegible]

Designation: SN Date: 11/8/15

Clinical Notes

Date and Time	Notes	Name, Signature and Designation
11/8/15 0225	Emergency admission via ATE following a collapse whilst walking along hospital corridor when visiting a relative. Unresponsive when brought into ATE.	
	GCS 3. Strong smell of alcohol ++.	
ATE	Awls narcan given but no	

Clinical Notes continue on next page

Clinical Notes (continued)

Date and Time	Notes	Name, Signature and Designation
CAT	response.	
	• seizure activity at 9am.	
	r/v by AFE consult - ? pseudo.	
	seizure.	
	• VBG lac 1.3 CH 38.7.	
ECG	• @ 2330 QCS ↑ 1.5 I I 5 spontaneously NH acute.	
CXR	Done en route to ward	
Impression	Collapse ? 2° Alcohol	
	intoxicate ? Pseudo Element.	
Plan	• ECG I CXR I Bloods incl VBG	
	• I fluids - no longer required.	
	• ? for further naloxone	
	• Medical r/v → ? day as	
	no medical problems	
	completed + no further	
	plan documented except	

NHS GREATER GLASGOW & CLYDE

1203893453
WEIR
James
M
12/03/1989

CLINICAL NOTES - NURSING

11/8/15

Date & Time		Signature, Print Name & Designation
Cont	A+E clerk in.	
	↓ if deteriorates for CT head +	
	intubated.	
O/A	to AMU: NEWS 0.	
A	Patent	
B	SPO2 96% on Air RR 15.	
C	BP ~~148~~ 118/72 HR 79bpm IVACCESS	
	x2 insitu, urine passed	
	PC fluids given	
D	AVPU temp 36.4 ACS 15/15 PEARL	
E	Pt indep mobile into bed.	
	Declined diet, water given.	
	NU further seizure activity.	
	Contacted A+E re: plan.	SN
	to observe as NU medics:	awaited
	have reviewed pt in A+E	[illegible]
0700	Appears to have had a	
	settled night, slept well.	
	News 1 BP 101/60.	
	ACS 15/15 PEARL.	
	NU seizure activity.	SN.
	Still awaits medical r/v.	[illegible]
11/8/15 0850	Pt not at bedside - hospital	
	gown on chair, no belongings left.	
	? venflon x2 green in site.	
	NOK contact number doesn't	
	work, numbers on Trakcare don't	
	work. Medics informed - would	
	be very difficult to detain patient	
	given his PMHx / mental health.	

193443

Date & Time		Signature, Print Name & Designation
	but should come back if has reasons in situ and can be assessed / persuaded to stay. Telephoned police Scotland, description given by medic as I have not seen patient due to shift change over.	Crime reference number
	Had been referred to Alcohol Addictions - they will check their system re Community Psychiatric Input.	Kim McCarrillo.

Emergency Department Nursing Documentation

NHS Greater Glasgow and Clyde

1203893450 Label
WEIR M
James 12/03/1989

Presenting Complaint: collapse / chest pain

Date and Time: 10/8/15 2020

Named Nurse(s): MCCORD

Patient preparation (Please tick when completed)	Initials:	Communication (Please tick when completed)	Initials:
Prepare patient for examination	☐	Communication Aids (spectacles / hearing aid)	☐
Provide blankets if required	☐	Relatives present?	☐
Clothing bagged, labelled and stored under trolley	☐	Relatives / NOK informed	☐
Name-band (if required)	☐	Interpreter required	☐
		Telephone interpretation required	☐

Observations and Investigations (Please tick when completed)		Initials:	
Vital Signs recorded on NEWS chart and NEWS score recorded. Record Pain, blood sugar and neuro obs on NEWS chart if appropriate.	☑	IV Cannula (if required) dated and timed	☑
Peak Flow 1. 2. 3.	☐	Blood samples taken	☐
12 Lead ECG	☑	Urinalysis and Specimen if indicated	☐
Cardiac Monitoring	☐	*Results:*	
X-rays performed	☐	HCG specimen if indicated	☐
		+ve ☐ -ve ☐ Strip Lot no:	
Other: please add	☐	Weight:	☐

Screening Tools (Please circle or tick as appropriate)		Initials:	
SEPSIS risk? SIRS Criteria 2 or more and suspicion of infection	Y / N	Preliminary Pressure Ulcer Risk Assessment The patient can reposition themselves whilst in the department?	Y (N)
AMT 4 (if >65 years) SCORE	/4	There is no reported skin damaged other than presenting trauma?	(Y) N
At risk of falls? (clinical judgement) (consider alcohol, mobility, age, illness, cognitive impairment etc). *If at risk complete risk assessment*	Y / N	The person is fully continent? *If NO to any of the above initiate Waterlow risk assessment (within 4 hrs)*	(Y) N
Mental Health Triage Assessment	Y / N	Waterlow Score *If >10 commence Active Care*	☐
Child Protection considered (in line with policy)	Y / N	Active Care (clinical judgement) (include all trolley patients at risk of pressure ulcers and all trolley patients in department for >4hrs) *Record on Active Care Chart*	☐
GMAWS	Y / N	Pressure damage identified on arrival in ED is documented in clinical notes	☐
Swallow test (if CVA/stroke)	Y / N	Grade 3 or 4 Pressure Ulcers are reported on DATIX	☐

Pause for Transfer (Please tick when completed)		Tick when completed	N/A	Notes
	Relatives informed	☐	☐	Information on discussion with relatives
	Cannula dated and timed	☐	☐	
	Name band	☐	☐	
	AMT4	☐	☐	
	NEWS chart	☐	Always	
Prescriptions signed	Infusions	☐	☐	
	Drugs	☐	☐	
	Fluids	☐	☐	
	GMAWS	☐	☐	
	Belongings (including patient's medications)	☐	Always	Please note here if any other tasks required prior to transfer
	Bed requested, accepted and ward informed	☐	Always	
	Notes: medical notes, GP letter, PRF	☐	Always	
Investigations	CXR reviewed	☐	☐	
	ECG reviewed	☐	☐	Print name
	Bloods sent	☐	☐	
	Bloods reviewed	☐	☐	
	Patient on O_2: cylinder checked	☐	☐	
	Patients requiring analgesia: sufficient	☐	☐	

Patient Addressograph Label

Pause for Discharge (Please tick when completed)	Tick when completed	N/A	Notes
Advice leaflets given	☐	☐	Information on discussion with relatives
Belongings (including patient's medications)	☐	Always	
New medications explained	☐	☐	
Cannula removed	☐	☐	
Relatives aware of discharge	☐	☐	Please note here if any other tasks required prior to discharge
Social/ Support Services required and contacted	☐	☐	
SAS transport required and ref no	☐	☐	Print name
Other means of transport arranged by nurse	☐	☐	

Nursing Notes

Date and Time		Print Name and Signature
21[illegible]	Arrived in RESUS 2020 - collapse in main corridor - GCS 3 - attended by Dr at scene.	
2120	A- Airway patent - not tolerating guedel airway B- RR 17 - 15- O2 SATS 100% on Air. C- HR 92 - Normotensive Given 2mg Narcan I.V - no response noted. D- "Seizure" activity witness noted to be pseudo seizures by DIE consultant. E- BM 5.2. GCS 10. Continue to monitor - await results.	
2240	Patient now GCS 15/15. Consultant in attendance.	
2330	A- Airway patent - conversant. B- RR 15 C- HR 80 - I.V access x2. No fluids at present. D- GCS 15. Tearful and reactive but unable to recall all events.	

Patient Addressograph Label

Nursing Notes

Date and Time		Print Name and Signature

Emergency Department - Active Care

I have evaluated and deemed that the frequency of care delivery over the next work shift, based on the patient's most critical need should be every:

(Please circle) ½ hour 1hour 2 hours

Signed ..... Name MM ECRS

Patient Addressograph Label

			Time							
	1.	PAIN: Assess and address If in pain inform registered nurse Y or N/A								
S	2.	SKIN INSPECTION A. Pressure areas checked:								
		B. Redness (R) / Discolouration (D) / Pressure Ulcer (PU)								
K	3.	KEEP MOVING: A. Have you moved or walked Y / N / I (independent)								
		B. Trolley Right side (30° tilt) – R Left Side (30° tilt) – L Back– B								
		C. Chair Assist to walk, stand or tilt (W /ST/ T)								
I	4.	ELIMINATION: Do you need the toilet? I = Independent A = Assistance given IC = patient incontinent of urine/faeces								
N	5.	FOOD, FLUIDS AND NUTRITION: Is the patient nil by mouth? Y / N (consider mouth care)								
		Encourage the patient to drink? (If appropriate) Y / N / N/A								
		Food, snack or supplement taken? (If appropriate) Y / N / N/A								
	6.	ENVIRONMENT: Is the patient able to call for assistance? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the trolley in lowest position?								
	7.	INFORMATION: Ask: Is there anything else I can help you with? Inform patient of the time of return.								
	8.	ESCALATION: Escalate any issues to the Registered Nurse / Dr Y / N/A								
		Nurse Initials								

USE FOLLOWING CODE	Specialist Pressure Redistributing equipment	Variations			
V = Variant I = Independent NT = No thanks	☐ Repose Mattress ☐ Moving and handling aids ☐ Other:	Time	No.	Variation	Signed

Waterlow Pressure Area Risk Assessment

Build/Weight		Skin Type/Visual Risk Areas		Sex/Age		Special Risks - Tissue Malnutrition	
Average (BMI 20-24.9)	0	Healthy	0	Male	1	Multiple organ failure/ Terminal cachexia	8
Above Average (BMI 25-29.9)	1	Tissue Paper (thin/fragile)	1	Female	2		
Obese (BMI > 30)	2	Dry (appears flaky)	1	14-49	1	Single organ failure	5
Below Average (BMI < 20)	3	Oedematous (puffy)	1	50-64	2	Peripheral Vascular Disease	5
Continence		Clammy /pyrexia	1	65-74	3	Anaemia = Hb < 8	2
Complete/Catheterised	0	Discoloured (bruising/mottled)	2	75-80	4	Smoking	1
Incontinent urine	1			81+	5	Neurological Deficit	
Incontinent faeces	2	Broken (established ulcer)	3	Nutritional Element		Diabetes/MS/CVA Motor or sensory paraplegia (Max 6)	4-6
Doubly Incontinent (urine and faeces)	3	Mobility		Unplanned weight loss in past 3-6 months < 5% Score 0 5-10% Score 1 > 10% Score 2			
		Fully mobile	0				
Special Risks – Surgery/Trauma		Restless/Fidgety	1			Special Risks - Medication	
On table > 6 hours	8	Apathetic (sedated/depressed/ reluctant to move)	2			Cytotoxic, anti-inflammatory, long term/high dose steroids (Max 4)	4
Orthopaedic / below waist/Spinal (up to 48 hrs post-op)	5			BMI > 20 Score 0 BMI 18.5-20 Score 1 BMI < 18.5 Score 2		Risk Score 10+ = 'At risk' 15+ = 'High Risk' 20+ = 'Very High Risk'	
On table > 2 hours (up to 48 hrs post op)	5	Bed bound (unconscious/unable to change position/traction)	4				
		Chair Bound	5	Patient acutely ill or no nutritional intake > 5 days	2		

Patient's initial Waterlow Score = If Score ≥10 Complete the Adapted Waterlow Pressure Area Risk Assessment Chart

NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

Name
Address
1203893450 12/03/1989
WEIR
James

CHI No.
DoB

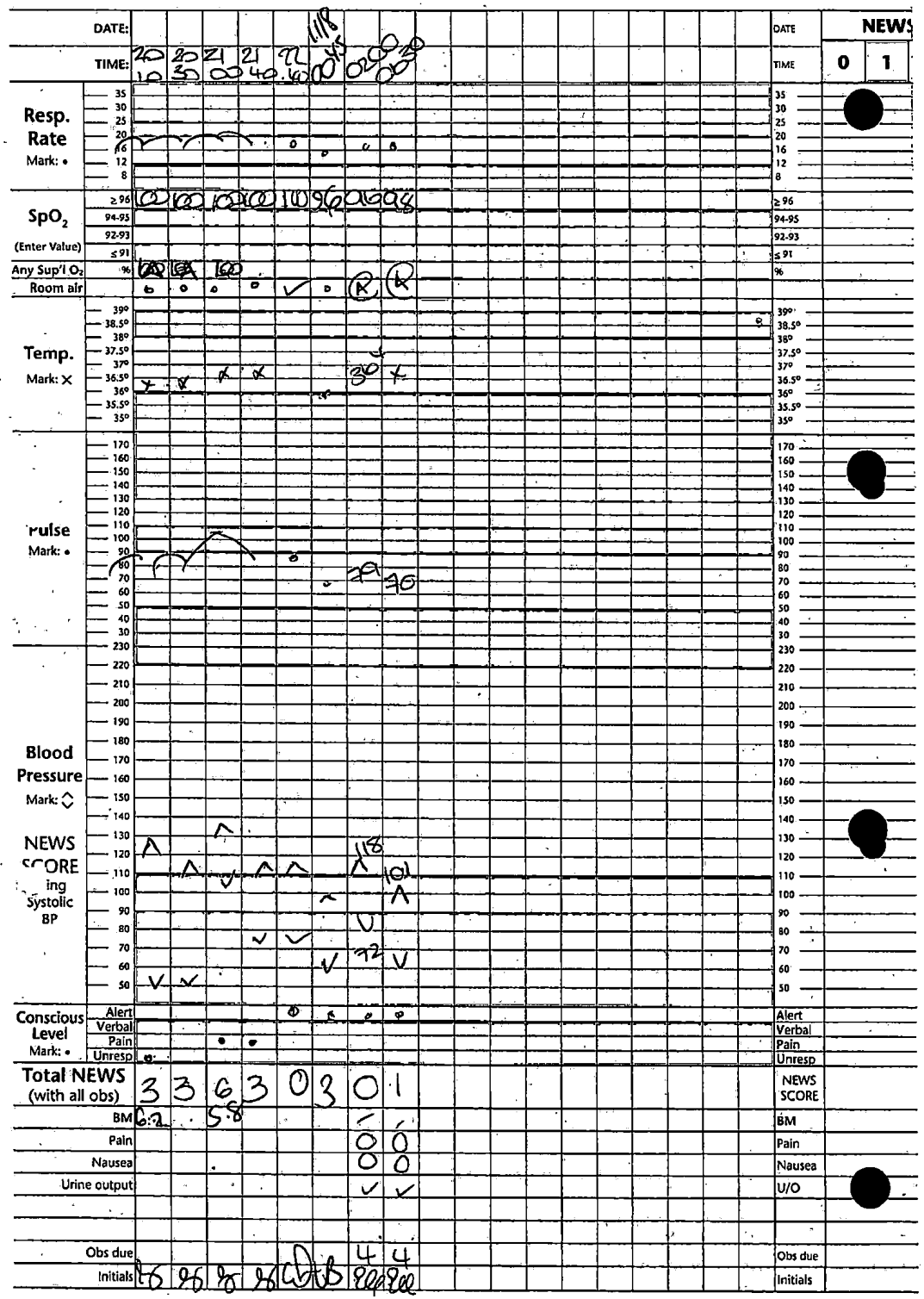
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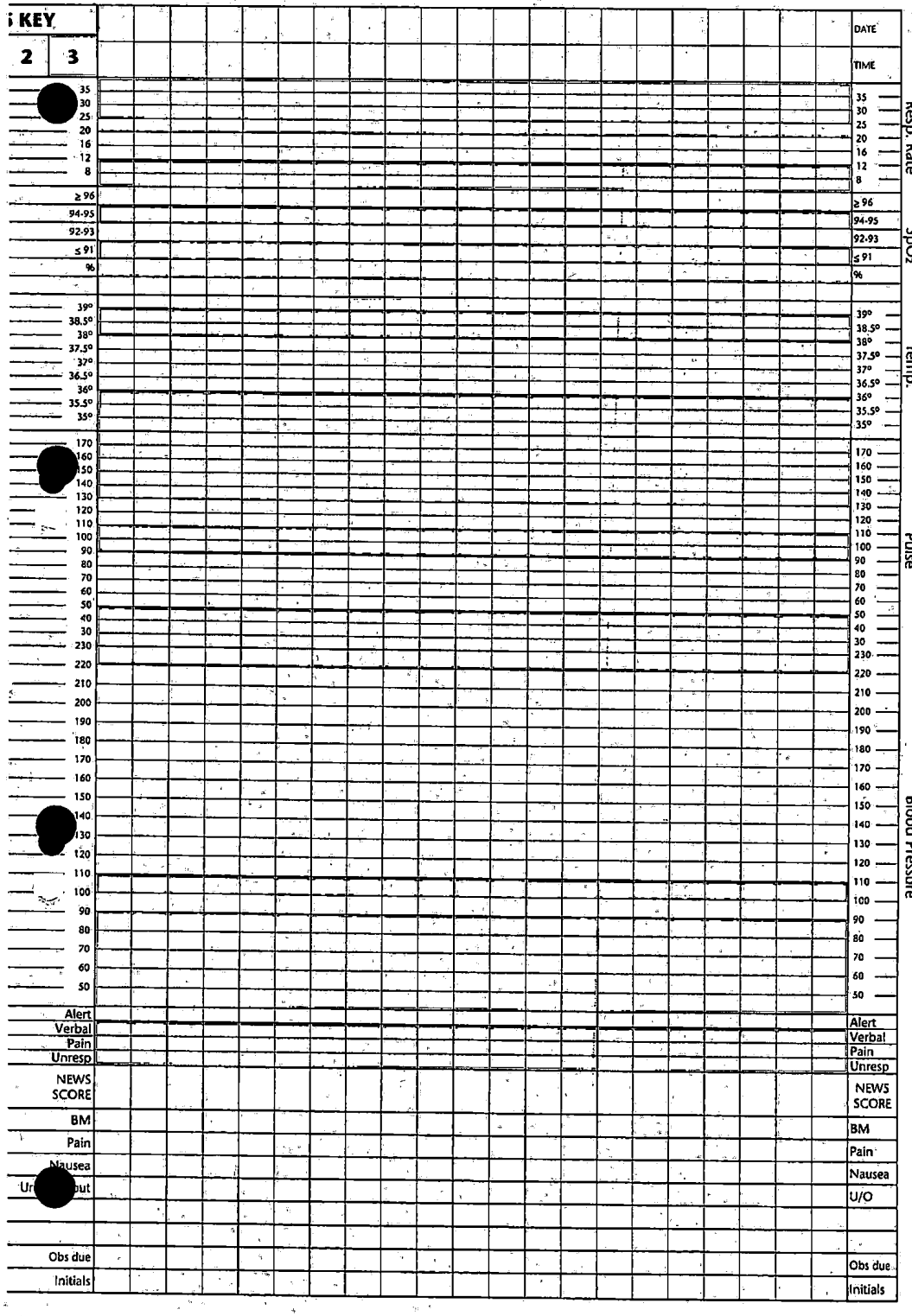
Physiological Parameter	NEWS – NHS Early Warning Score						
	3	2	1	0	1	2	3
Respiration Rate	≤8		9-11	12-20		21-24	≥25
Oxygen Saturations	≤91	92-93	94-95	≥96			
Any Supplemental Oxygen		Yes		No			
Temperature	≤35.0°		35.1-36.0°	36.1-38.0°	38.1-39°	≥39.1°	
Pulse	≤40		41-50	51-90	91-110	111-130	≥131
Systolic BP	≤90	91-100	101-110	111-219			≥220
Conscious Level				A			V, P or U

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

See NEWS Actions Reference Tool for local escalation policy

NEWS Score	Frequency of Monitoring	Clinical Response
0	Minimum 12 hourly	• Continue routine NEWS monitoring with every set of observations.
Aggregate 1- 4	Minimum 4 hourly	• Inform trained nurse. • Trained Nurse assessment: - Assess the patient - Review frequency of monitoring required - Assess need for escalation of clinical care and direct as appropriate.
Aggregate 5 or more or 3 in one parameter	Increased frequency to a minimum of 1 hourly	• Trained Nurse assessment. • Inform medical team caring for the patient. • Urgent assessment by a medical / surgical / nursing team with core competencies to assess acutely ill patients. • Consider level of monitoring required in relation to clinical care.
Aggregate 7 or more	Continuous monitoring of vital signs	• Trained Nurse to assess immediately. • Inform medical team caring for the patient – this should be at least senior medical staff level. • Emergency assessment by a clinical team with core competencies in the assessment of critically ill patients. This team will have critical care competencies and a practitioner/s with advanced airway skills and resuscitation skills. • Consider referral to high dependency or ITU.


DATE:
TIME:
Resp. Rate
Mark: •
SpO2
(Enter Value)
Any Sup'l O2
Room air
Temp.
Mark: ×
Pulse
Mark: •
Blood Pressure
Mark: ◇
NEWS SCORE
ing Systolic BP
Conscious Level
Mark: •
Alert
Verbal
Pain
Unresp
Total NEWS (with all obs)
BM
Pain
Nausea
Urine output
Obs due
Initials
DATE
TIME
NEWS
0
1
NEWS SCORE
BM
Pain
Nausea
U/O
Obs due
Initials


KEY
2
3
DATE
TIME
Resp. Rate
35
30
25
20
16
12
8
SpO2
≥ 96
94-95
92-93
≤ 91
%
Temp.
39°
38.5°
38°
37.5°
37°
36.5°
36°
35.5°
35°
Pulse
170
160
150
140
130
120
110
100
90
80
70
60
50
40
30
Blood Pressure
230
220
210
200
190
180
170
160
150
140
130
120
110
100
90
80
70
60
50
Alert
Verbal
Pain
Unresp
NEWS SCORE
BM
Pain
Nausea
U/O
Obs due
Initials

Neurological Observations

| | | |

NHS Greater Glasgow and Clyde
Active Care Checklist

Date: 11/8/15

Attach Addressograph
120389345C
WEIR
James M
12/03/1989
27D MACDOWALL STREET
Johnstone, Renfrewshire
PA5 8QJ

Ward:

NHS Greater Glasgow and Clyde

I have evaluated and deemed that the frequency of care delivery over the next work shift, based on the patient's most critical need should be every (Please circle): 1hr 2hr 3hr 4hr 6r

1. Signed [signature] Name [illegible] Designation SN
2. Signed ..... Name ..... Designation .....
3. Signed ..... Name ..... Designation .....

Individual patient needs: Red mat required: Y / N Bed rails: Y / N
'Must do's' for me. Ask the patient if there is anything they want specifically done today:
.....

USE FOLLOWING CODE:
O = Off the ward V = Variant S = Sleeping I = Independent NT = No Thanks

			Times	0800	0830																		
	1.	Pain: assess and address If in pain inform registered nurse Y / N or N/A		N	N																		
S	2.	SKIN INSPECTION Pressure areas checked: Y / N / I (Independent)		I	I																		
		Redness (R) / Discolouration (D) / Pressure Ulcer (PU) / Intact (INT)		Int	Int																		
K	3.	KEEP MOVING: Have you moved or walked Y / N / I (independent)		I	I																		
		Bed Right side (30° tilt) – R Left Side (30° tilt) – L Back– B		—	—																		
		Chair Assist to walk, stand or tilt (W /ST/ T)		—	—																		
I	4.	ELIMINATION: Do you need the toilet? I = Independent A = Assistance given IC = patient incontinent of urine or faeces		I	I																		
N	5.	FOOD, FLUIDS AND NUTRITION: Is the patient nil by mouth? Y / N (consider mouth care)		N	N																		
		Encourage the patient to drink? Y / N / N/A		Y	Y																		
		Food, snack or supplement taken? Y / N / N/A		Y	Y																		
	6.	ENVIRONMENT: Check: Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position? Y/N/O/S		Y	Y																		
	7.	INFORMATION: Ask: Is there anything else I can help you with? Inform patient of the time of return. Y/N/O/S		NT	NT																		
	8.	ESCALATION: Escalate any issues to the Registered Nurse Y / N/A		N	N																		
		Nurse Initials		[illegible]	[illegible]																		

1203893450
WEIR M
James 12/03/1989
27D LACCOWALL STREET
Johnstone, Renfrewshire
PA5 8QJ

NHS Greater Glasgow and Clyde

Peripheral Vascular Cannula(PVC) Insertion & Maintenance

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

Insertion – Complete all sections

PVC inserted	Date inserted	Insertion site	Colour of PVC	Inserted by: Name & Designation [only if legible in word]
ED ✓ Theatre Ward_____	11/8/15	Lt R ACF	Green	

Clinical Indication	IV Fluids/IV Medication ☑	Urgent access ☐	Interventional procedures ☐	Other Please state:

Insertion Criteria (If no: please explain in comments below)	Clean field used	Hand hygiene	Skin asepsis	Dressing affixed	Non touch technique (do not re- contaminate cleaned skin)
	Yes ☐ No ☐ Unknown ☑	Yes ☐ No ☐ Unknown ☑	Yes ☐ No ☐ Unknown ☑	Yes ☑ No ☐ Unknown ☐	Yes ☐ No ☐ Unknown ☐

Maintenance – To be completed daily

PVC 1	Has the PVC been used in the past 24 hours?	Absence of inflammation and or extravasation Record VIP score	The PVC dressing is intact	The PVC has been inserted less than 72 hours	Hand hygiene before & after all procedures	If answer is no to any of the criteria or if VIP 2 or more and PVC left in situ: document rationale for decision in comments	Initial
Day 1 __/__/__	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
Day 2 __/__/__	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
Day 3 __/__/__	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
After day 3 consider removal, if there is still a clinical reason justify rationale for PVC to remain in situ.							
Day 4 __/__/__	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
Day 5 __/__/__	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	

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

Date & time	PVC no.	Comments	Signature

MIS 269426
81117

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

Insertion – Complete all sections

PVC inserted ED Theatre Ward_____	Date inserted	Insertion site	Colour of PVC	Inserted by: Name & Designation *(only if inserted in ward)*
Clinical indication	IV Fluids/IV Medication ☐	Urgent access ☐	Interventional procedures ☐	Other Please state:
Insertion Criteria (If no: please explain in comments below)	Clean field used Yes ☐ No ☐ Unknown ☐	Hand hygiene Yes ☐ No ☐ Unknown ☐	Skin asepsis Yes ☐ No ☐ Unknown ☐	Dressing affixed Yes ☐ No ☐ Unknown ☐	Non touch technique (do not re- contaminate cleaned skin) Yes ☐ No ☐ Unknown ☐

Maintenance – To be completed daily

PVC 2	Has the PVC been used in the past 24 hours?	Absence of inflammation and or extravasation Record VIP score	The PVC dressing is intact	The PVC has been inserted less than 72 hours	Hand hygiene before & after all procedures	If answer is no to any of the criteria or if VIP 2 or more and PVC left in situ: document rationale for decision in comments	Initial
Day 1 __/__/____	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
Day 2 __/__/____	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
Day 3 __/__/____	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
After day 3 consider removal, if there is still a clinical reason justify rationale for PVC to remain in situ.							
Day 4 __/__/____	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
Day 5 __/__/____	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	

Date & time	PVC no.	Comments	Signature

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

NHS
Greater Glasgow and Clyde

NATVNS
SCOTLAND

1203893450
WEIR M
James 12/03/1989
2.2 MACDONALL STREET
Johnstone, Renfrewshire
PA5 8QJ

ADAPTED WATERLOW PRESSURE AREA RISK ASSESSMENT CHART

More than one score/category can be used: **10+= 'At Risk': 15+= 'High Risk': 20+= 'Very High Risk'**

Complete assessment on admission/1st visit, if there is a change in individuals condition and repeat regularly according to local protocol

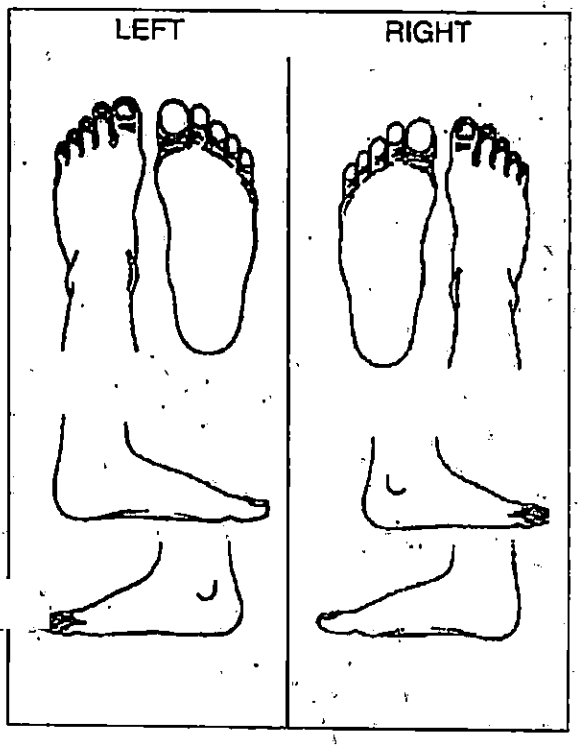
Sex									
Male	1	✓							
Female	2								
Age									
14 -49	1	✓							
50 -64	2								
65 - 74	3								
75 - 80	4								
81+	5								
Build/Weight for Height (BMI=weight in Kg/height in m²)									
Average - BMI 20-24.9	0	✓							
Above average - BMI 25-29.9	1								
Obese - BMI > 30	2								
Below average - BMI < 20	3								
Continence									
Complete/catheterised	0	✓							
Incontinent urine	1								
Incontinent faeces	2								
Doubly incontinent (urine & faeces)	3								
Skin Type - Visual Risks Area									
Healthy	0	✓							
Tissue paper (thin/fragile)	1								
Dry (appears flaky)	1								
Oedematous (puffy)	1								
Clammy (moist to touch)/pyrexia	1								
Discoloured (bruising/mottled)	2								
Broken (established ulcer)	3								
Mobility									
Fully mobile	0	✓							
Restless/fidgety	1								
Apathetic (sedated/depressed/reluctant to move)	2								
Restricted (restricted by sever pain or disease)	3								
Bedbound (unconscious/unable to change position/traction)	4								
Chairbound (unable to leave chair without assistance)	5								
Nutritional Element									
Unplanned weight loss in past 3-6 months									
<5% Score **0**, 5-10% Score **1**, >10% Score **2**	0-2								
BMI > 20 Score **0**, BMI 18.5-20 Score **1**, BMI < 18.5 Score **2**	0-2								
Patient acutely ill or no nutritional intake > 5 days	2								
Special Risks - Tissue Malnutrition									
Multiple organ failure/terminal cachexia	8								
Single organ failure e.g. 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								
Special Risks - Surgery/Trauma									
On table > 6 hours	8								
Orthopaedic/below waist/spinal (up to 48 hours post op)	5								
On table > 2 hours (up to 48 hours post op)	5								
Special Risks - Medication									
Cytotoxic, anti-inflammatory, long term/high dose steroid *Max 4*	4								
Total Score		7							
Date		11/8							
Initials		RG							
Time		0800							

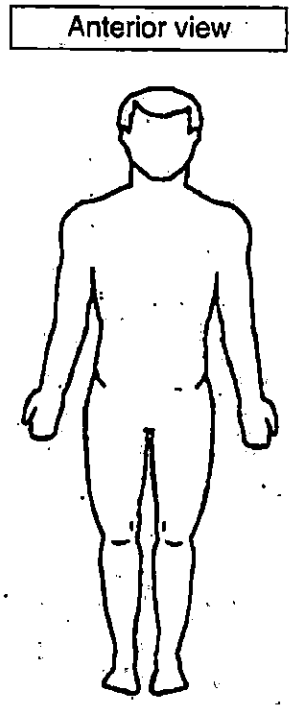
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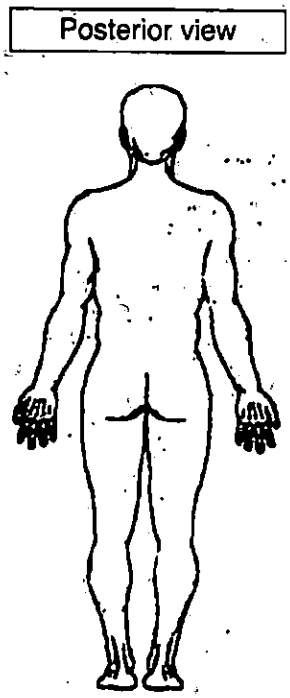
Ensure plan of care is implemented / reviewed for all identified areas of concern.

PRESSURE ULCER RECORD

Indicate by circling and numbering all pressure damage on diagrams, then complete box below. Indicate care plan/wound assessment chart.







SCOTTISH ADAPTED EPUAP PRESSURE ULCER GRADING TOOL

GRADE 1 Non-blanchable erythema of intact skin. Discolouration of the skin, warmth, oedema, induration or hardness may also be used as indicators, particularly on individuals with darker skin.

GRADE 2 Partial thickness skin loss involving epidermis, dermis or both. The ulcer is superficial and presents clinically as an abrasion or blister.

GRADE 3 Full thickness skin loss involving damage to or necrosis of subcutaneous tissue that may extend down to, but not through underlying fascia.

GRADE 4 Extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures with or without full thickness skin loss.

DATE	NUMBER OF ULCER(S)	LOCATION OF ULCER(S)	GRADE OF ULCER(S)	LOCATION OF ULCER(S)

Pressure Ulcers may deteriorate from Grade 1 to Grade 4, but can not be reversed and should be documented as a healing grade of pressure ulcer, eg healing grade 4.

Acute Services Division

Hospital / Department | Medicine

NHS Greater Glasgow and Clyde

Cannard Falls Risk Assessment Pack

1203893450
WEIR M
James 12/03/1989
27D MACDOWALL STREET
Johnstone, Renfrewshire
PA5 8QJ
Unit/Hospital number

Contents

1. Canard Falls Risk Assessment Scoring Form
2. Falls Assessment Care Plan
3. Glossary of terms used in risk assessment

Notes: Risk assessment should be completed within 24 hours of admission to each ward.

Assessment Wards: Risk assessment and care plan should be reviewed weekly.

Continuing Care Wards: Risk assessment and care plan reviewed monthly.

Referral Criteria for Hospital Falls Prevention Co-ordinator

1. Cannard score of 18+.
2. Second or subsequent fall
3. Significant Injury caused by a fall. (Significant Injury defined as any fracture, significant bruising or laceration to head or body.)

The patient should be referred with any of the above criteria.

General Safety Precautions

- Ensure patient has buzzer to hand
- Check patient has the manual dexterity and cognitive ability to operate buzzer
- Place personal items within easy reach
- Keep the bed in lowest position possible (use low bed if available)
- DO NOT leave patients with cognitive impairment unattended on commodes, in toilets, baths and showers.
- Patients with poor mobility, who are known not to ask for assistance, should not be left unattended on commodes, toilets, baths and showers.
- If noted that mobility / transfers are unsafe refer to physio / OT for assessment
- If patient wears glasses, ensure they are clean
- Ensure patient's footwear is adequate
- Lock wheels on all wheelchairs, beds, commodes and trolleys when in use
- Provide adequate lighting at night
- Request medication review if appropriate
- Clean up spills immediately
- Orientate patient to the ward environment

Cannard Falls Risk Assessment

(Must be completed within 24 hours of admission to each ward)

SCORE ALL OPTIONS THAT APPLY IN EACH SECTION						Date: 1/18 / Ward: AMU	Date: / Ward:	Date: / Ward:	Date: / Ward:	Date: / Ward:	Date: / Ward:	Date: / Ward:
History of falls in the last 6 months	At home 1	In ward / unit 2	None 0			0						
Sex	Male 1	Female 2				1						
Age	13-59 0	60-70 1	71-80 2	81+ 1		0						
Sensory deficit	Sight* 2	Hearing* 1	Balance* 2	None 0		0						
Medication type **	Drugs for mental illness 1	Blood pressure / water tablets 1	Sleeping tablets 1	None of these 0		0						
Medical history	Diabetes 1	Confusion 1	Fits 1	Incontinent 1	Inability to cooperate* 1	0						
Mobility	Fully mobile 1	Uses aids 2	Restricted* 3	Bed / chair-bound/ wheel-chair 1		1						
Gait	Steady 1	Hesitant in initiating movement* 1	Poor transfer* 3	Unsteady 3		1						
				TOTAL SCORE		3						
				ACTION(S) TAKEN Enter action code(s) from Care Plan below		↓						
SCORE 13+ = HIGH RISK If patient unconscious score as N/A until patient status improves.				NURSE SIGNATURE								

Please see back page for glossary of terms relating to the assessment above.

Falls Assessment Care Plan

Please tick all applicable nursing interventions

	NURSING INTERVENTIONS	Date: 11/8 Ward: PMH	Date: Ward:	Date: Ward:	Date: Ward:	Date: Ward:	Date: Ward:	Date: Ward:
Action code								
1	Falls prevention and general safety precautions discussed with patient and family.							
2	Move to more observable area of ward to optimise supervision.							
3	Advise patient they may experience dizziness when they mobilise initially.							
4	Requires assistance with mobilisation.							
5	Observe trip hazard due to invasive lines, drains and catheters.							
6	Do not leave the patient unattended when using commode, toilet, in shower or the bathroom area.							
7	If patient is unable/unwilling to cooperate with intervention, advise medical staff and MDT.							
8	Monitor lying and standing / sitting BP and pulse.							
9	A. Patient requires footwear or podiatry referral. (Date referred: / requested :) B. Request family / carer to provide suitable footwear.	A						
10	Commence continence assessment, follow Local Guidelines.							
11	Refer to Occupational Therapist.							
12	Select suitable seating (refer to policy).							
13	Non slip mat on chair /floor following advice from therapists.							
14	Refer to Physiotherapist.							
15	Review Transfer techniques.							
16	Request medication review.							
17	Bed/chair monitor in use.							
18	Falls map in use for seven days for patient who has second or subsequent falls.							
19	Bed rails/bumpers to be used (refer to policy).							
20	Patient requires low bed / mattress on the floor (refer to policy.)							
21	Patient requires one to one nursing care.							
22	Refer to Hospital Falls Prevention Co-ordinator (see criteria on front cover).							
23	Other interventions.							

Review Cannard score weekly / monthly as per policy. Enter action code(s) selected in action taken section on Falls Risk Assessment page above.

1203893450
WEIR M
James 12/03/1989
27D MACDOWALL STREET
Johnstone, Renfrewshire
PA5 8QJ

Care Plan

NHS Greater Glasgow and Clyde

Date Commenced and Signature	1. Breathing and circulation	Date Discontinued and Signature	Date Commenced and Signature	7. Personal Hygiene, oral care and skin care	Date Discontinued and Signature
11/8/20	NEWS 0		11/8/20	indep	
	ACS ISIS				
	NO ISSUES				
	2, 3. Communication and senses		11/8/20	8. Mobility	
11/8/20	NO ISSUES			indep	
11/8/20	4. Cognitive status		11/8/20	9. Maintaining a safe environment	
	oriented			NO ISSUES	
11/8/20	Getting to Know Me / What matters to me		11/8/20	10. Sleep and Rest	
	NO ISSUES			NO ISSUES	
11/8/20	5. Hydration and Nutrition		11/8/20	12. Privacy, dignity and sexuality	
	(N) fluid + diet			NO ISSUES	
11/8/20	6. Elimination		11/8/20	Negotiated care - (Yes) / No Care discussed with patient / family Yes / No Patient able to participate Yes / No	
	cont				

223591

Care Plan Guidance

Below are some prompt questions to help you record the individualised care that your patient requires during their inpatient stay. You should record the care that the nurse / nursing staff require to provide. The 'Negotiated Care' component provides opportunity to record any care that the patients family or carers are participating in and care that patients are being taught to support changing self care. If the patient is independent in any of the activities of living and requires no nursing intervention then you should record this in the relevant section.

When care changes a note should be made in the nursing clinical notes / progress notes to confirm why this is required.

1. Breathing and circulation	7. Personal Hygiene, oral care and skin care
Record frequency of observations, TPR BP and SAO2. Record any other care that the patient requires for their breathing or their circulation e.g. seating position, apex beat with radial pulse, pedal pulse measurement, lying and standing Blood Pressure measurement etc.	Does the patient need assistance with personal hygiene? If so what needs to be done. Do they require assistance with oral care? If so what is this. Does the patient require any specifc pressure area care outwith the Active Care documentation. If totally independent record 'self caring'.
2, 3. Communication and senses	**8. Mobility**
What assistance does the patient need with communication? If they use spectacles or a hearing aid what assistance do they needs with these? Does the patient require an interpreter?	Does the patient require assistance when mobilising? Does the patient use mobility aids? Is the patient at risk of falling? Record key information from falls risk assessment, e.g. Cannard tool, to prevent falls
4. Cognitive status	**9. Maintaining a safe environment**
What care is required to minimise risk of harm due to behavioural disturbance? Think about capacity and adults with incapacity and what you need to do with the patient to alleviate distress.	How is the patients pain being assessed? Is a specific pain assessment tool used? What does the patient require to maintain their safety?
Getting to Know Me / What matters to me	**10. Sleep and Rest**
The 'Getting to know me' Document should be used for all patients with cognitive impairment. Once completed by the patients relatives / carer record the key information to plan care in the care plan. Ask the patent what matters to them during their hospital stay and record in this area.	What would help the patient achieve a good nights rest? Does the patients sleep pattern need to be monitored? if yes record what needs to be done.
5. Hydration and Nutrition	**12. Privacy, dignity and sexuality**
Does the patient require any assistance with eating and / or drinking? Does the patient require a special diet? Do they require fluid balance monitoring?	What do you need to do to maintain the patients modesty and dignity?
6. Elimination	**Negotiated care -** Care discussed with patient / family Yes / No Patient able to participate Yes / No
Does the patient require assistance to go to the toilet? Do they use continence aids? Does their urinary output require to be monitored? Are the patients stools / bowel activity being monitored?	Discuss patient care needs with them. If the patient is learning a new self care procedure record their process and progress of learning. If the patient has a learning disability or dementia use the information obtained in the Getting to Know Me document to identify the care that the family / carer could participate in.

ROYAL ALEXANDRA HOSPITAL
Day Surgery Unit
Patient Assessment and Clinical Documentation

Date of Admission	Day	Month	Year
	22	05	15

1203893450 WEIR M James 12/03/1989 27D MACDOWALL STREET Johnstone, Renfrewshire PA5 8QJ	Preferred Name: Next of Kin: Telephone No.:	Consultant: Dr Heydtmann GP: Address:

		Yes	No
1.	Able to be ESCORTED home with own TRANSPORT		
2.	TELEPHONE at home / easy access to one		
3.	Easy access to a TOILET at home		
4.	RESPONSIBLE ADULT at home ABLE to stay 24 hours		

5.	Time to travel home		hours	minutes

Have you ever suffered from any of the following:		Yes	No
6.	Chest pain on exertion or at night		
7.	Breathlessness		
8.	High blood pressure		
9.	Heart murmur		
10.	Fainting easily		
11.	Convulsions / fits		
12.	Jaundice		
13.	Indigestion / Heartburn		
14.	Kidney / urinary trouble		
15.	Anaemia or other blood disorders		
16.	Excessive bleeding or bruising		
17.	Arthritis		
18.	Muscle disease or progressive weakness		
19.	Diabetes		

If patient has diabetes, is it controlled by: Diet ☐ Hypoglycaemics ☐ Insulin ☐

Has patient ever had:		Yes	No
20.	An allergy to a general anaesthetic		
21.	Allergy / reaction to medication / elastoplast etc.		
22.	A serious illness		
23.	Previous surgery If so, were there any complications		

Does the patient?	Yes	No
24. Take any medications / tablets / patches / inhalers		
25. Smoke		
If yes, type:	Quantity:	

26. Drink alcohol		
If yes, number of units per week:		

27. If female is she pregnant / on the pill

28. Is there anything else that the anaesthetist or surgeon should know? (state)

Weight kg	Height m	BP	Hb Blood Group
Pulse Reg/Irreg	Temp.	Resp Reg / Irreg	BMI
BM STIX	Urinalysis	U's & E's	ECG

Date of LMP Day | Month | Year

ASA 1 | 2 | 3 | 4 | 5

Patient's signature Date

Assessor's comments

Assessor's signature Date

Referred for anaesthetist's opinion	Yes		No	
Anaesthetist's comments				
Anaesthetist's signature		Date		

1203893450
WEIR
James
M
12/03/1989

List allergies: Penicillin

List Drugs Venlafaxine

Date of Birth:

Date of Admission: 22.05.15

Past Medical History

Right leg 2008 Alcohol related seizure
Haematemesis
Alcohol excess
Heroin abuse

Pre-operative base line observations

BP	Pulse Reg/Irreg	Resp Reg/Irreg	Temp
122/80	67	16	✓
Urinalysis	**BM STIX**	**Sa O_2**	**Blood Results**
✓	✓	98%	Hb: Group:

Proposed Procedure: Gastroscopy

	NA	YES	NO
Pre-operative assessment and checklist — Responsible Adult 24Hrs Post Op.			✓

Next of Kin: Sister: Debbie Weir — Person collecting: Alone

Telephone: 07588 5199 64 — Telephone:

	Yes	No		Yes	No
Travel Bus/Taxi	✓		Identiband in situ with Correct Name Unit Number	✓	
Access to telephone	✓		Consent form signed by Patient/Guardian* (* Delete as appropriate)	✓	
Diabetic		✓	Identiband and consent match Theatre list & case notes	✓	
Convulsions / fits Alcohol related 6/12 ago	✓		Premedication given	N/A	
Medications	✓		Fasted 21:00 · food 21:00 Thurs, sips iru bru 08:00 today		
Anticoagulants		✓	Bowel Prep (If NEC)	N/A	
Allergies	✓		Skin prep	N/A	
Coughs / colds		✓	Urine voided	✓	
Understanding of procedure	✓		Dentures / caps / crowns / loose teeth	upper plate	
Pregnant			Hearing aid / contact lenses / pacemaker	—	
Pill Contraceptive			Jewellery removed / taped		✓
Date of LMP			Make-up / nail varnish removed		✓
Sanitary Protection Insitu			Case notes / X-rays / films		✓
Mobility Assessed			Operation site marked	✓	
Preparation Complete					✓

Comments: * James requesting throat spray only please

Named nurse's signature

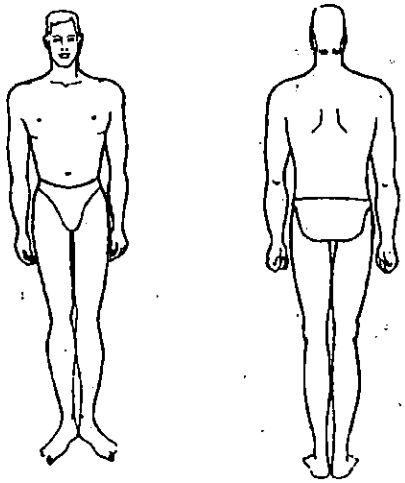
Admitting nurse's signature M/Cassley

Theatre nurse signature

Intra-Operative Care

ANAESTHETIC ROOM **Anaesthetic Nurse Signature:**

PATIENT MONITORING



PERIPHERAL IVI	X
IV CANNULLAE	C
ECG ELECTRODES	☐
CVP	Z
ARTERIAL LINE	A
BP MANUAL / AUTO	B
PULSE OXYMETER	●
DIATHERMY PLATE	▲
TEMPERATURE PROBE	H
EYES TAPED	I
THROAT PACK IN	T
OUT	

TYPE OF ANAESTHETIC

GENERAL	☐	SPINAL	☐	SEDATION	☐
LOCAL	☐	EPIDURAL	☐	THROAT SPRAY	☑

REGIONAL BLOCK (TYPE) _____

TYPE OF AIRWAY

ETT	☐	GUEDAL	☐
LMA	☐	NASAL	☐

THEATRE

SCRUB NURSE: _____

CIRCULATING NURSE:

Patient Position	Right Lateral		Trendelenburg		Prone		Lithotomy	
	Left Lateral	✓	Lloyd Davis		Supine		Jack Knife	
	Other		Semi - Upright					
Right Arm	At Side	✓	On Board		Across Chest		Other	
Left Arm	At Side	✓	On Board		Across Chest		Other	
Patient Protection Safety	Head Ring		J. Board + Padding		Pillows	✓	Warming Blanket	
	Gel Pad		Padding / Ties Arms		Flowtron Boots		Heel Rests Padding	
	Other	✓	Bed Rails.					
Diathermy	B I Polar		Mono Polar		Pad Correctly Applied		Site Check Satisfactory	
Tourniquet	Arm		Right		Time On		Site Check Satisfactory	
	Leg		Left		Time Off			
Skin Prep	**Solution Used**							

Swab / Needle / Instrument Count

SWAB COUNT	1st	☐	CORRECT ☐	INCORRECT	☐
	FINAL	☐	CORRECT ☐	INCORRECT	☐
	LOT 489895				
INSTRUMENT			RAY Nos.	CORRECT ☑	INCORRECT ☐
	OLY_OIF-H260_2734849				
DISCREPANCIES	X-RAY PERFORMED	YES	☑ error cl.	NO	☑
	INCIDENT REPORT CARRIED OUT	YES	☐	NO	☑

SCRUB NURSE SIGN	A Findlay
CIRCULATING NURSE SIGN	C Mullen

1245 P. 87 Sat 96% AIR

SPECIMEN TAKEN	TIME	YES	☑	NO	☐
	TISSUE	☑	ORGAN ☐	BLOOD	☐
	PATHOLOGY	☐	BACTERIOLOGY ☐	FROZEN SECTION	☐
	OTHER clo	☑			

BLOOD LOSS MEASURED	YES	☐	NO ☑

OPERATION

Gastroscopy + clo test

Xylocaine spray to throat @1240.

Discomfort score - (2).

DRESSING		**WOUND DRAINAGE**	
URINARY CATHETER		**LA INFILTRATION**	
PACKS IN SITU		**MEDICATION**	
RETURN APP.	GP for clo test result ⇒ 10 days.	**SUTURE REMOVAL**	
		No. OF SUTURES	

INSTRUCTIONS & CONTINUATION patient wishes to try only with throat spray NBM until shallow reflex returns.

Post Operative Care Plan

Recovery Nurse:

Conscious Level		Airway Management		Oxygen Therapy		IV Access	
Unconscious	☐	ET ☐	LMA ☐	Mask ☐	T-Piece ☐	Patent IVI	☐
Conscious / Drowsy	☐	Guedel ☐	Nasal ☐	Other ☐	%Age ☐	Venflon Insitu	☐
Conscious / Responsive	☐	Maintaining Own	☐	Nasal Cannula	☐	Discontinued	☐
Ventilated	☐	Time Airway Removed	☐	Discontinued at	☐	Site Check Satisfactory	☐

Post Operative Care: 1st Stage Recovery

Time										
Pulse										
Blood pressure										
Saturation (S_aO_2)										
Respiratory rate										
Pain score										
Sedation Score										
Nausea / Vomiting										
Temperature										
Wound										
Staining										
Venflon removed										
Colour										
Sensitivity										
Movement										

No sedation

Pain score
0 = No pain
1 = Discomfort at rest
2 = Pain on movement
3 = Pain at rest
4 = Severe pain at rest

Sedation Score
0 = Alert
1 = Responsive to verbal commands
2 = Responsive to painful stimuli
3 = Unresponsive

Nausea / vomiting
0 = No nausea / vomiting
1 = Mild
2 = Moderate
3 = Severe

Staining
0 =No staining
1 =Minimal
2 = Moderate
3 = Copious

Nurse signature:

PROBLEM / NEED	INTERVENTION	OUTCOME

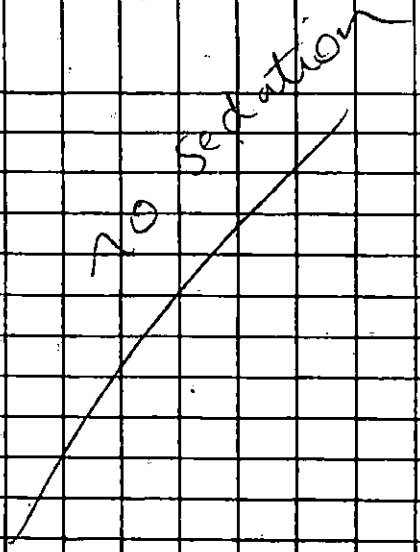
PATIENT HANDOVER TO WARD NURSE TIME ☐

RECOVERY NURSE SIGN: _____

WARD NURSE SIGN:

Post Operative Care: 2nd Stage Recovery

Time										
Pulse										
Blood pressure										
Saturation (S_aO_2)										
Respiratory rate										
Pain score										
Sedation Score										
Nausea / Vomiting										
Temperature										
Wound										
Staining										
Venflon removed										
Colour										
Sensitivity										
Movement										



Pain score
0 = No pain
1 = Discomfort at rest
2 = Pain on movement
3 = Pain at rest
4 = Severe pain at rest

Sedation Score
0 = Alert
1 = Responsive to verbal commands
2 = Responsive to painful stimuli
3 = Unresponsive

Nausea / vomiting
0 = No nausea / vomiting
1 = Mild
2 = Moderate
3 = Severe

Staining
0 =No staining
1 =Minimal
2 = Moderate
3 = Copious

Nurse signature:

Specific Post Op Problems

Problems	Action taken	Outcome	Signature

Comments

Nurses Signature:

Discharge Protocol

No Sedation.

Information / Instructions	Yes	No	N/A	Physical Observations	Yes	No	N/A
Received verbal & written instruction	✓			Stable vital signs BP/ P/ T/ R/			
Given contact number	✓			Minimal nausea, vomiting dizziness or pain			
Responsible person to accompany			✓	Able to cough, swallow and retain oral fluids			
Dressing(s) checked			✓	walk and dress with out assistance			
GP and/or community health services informed	✓			Absence of respiratory distress			
Health education			✓	Alert and orientated to person, place and time			
Appliances supplied			✓	Minimal bleeding / drainage / dressings checked			
Ambulance ordered			✓	Ability to void			
Discharge prescription given		✓		Anti D Required			
Return Appointment TBA			✓	Anti D Given			
Medication to take home N.L.							

Patients destination						
Home	✓	Retained overnight		Other		

Evaluation / summary

13.10 Water tolerated

HOME UNACCOMPANIED. 13.10.

Nurses Signature JPayne

Continuation Sheet	Signature

Consent Form

Patient agreement to endoscopic investigation or treatment

1203893450
WEIR M
James 12/03/1989
27D MACDOWALL STREET
Johnstone, Renfrewshire
PA5 8QJ

Name of Procedure

Gastroscopy/ Endoscopy/ Oesophago-gastro-duodenoscopy

Inspection of the upper gastrointestinal tract with a flexible endoscope (with or without biopsy and photography)

Biopsy specimens will be retained.

Statement of Patient

You have the right to change your mind at any time, including after you have signed this form.

I have read and understood the information in this booklet including the benefits and any risks.

I agree to the procedure described in this booklet and on the form.

I understand that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however have appropriate experience.

Where a trainee performs this examination, this will be undertaken under supervision by a fully qualified practitioner.

I understand that any procedure in addition to that named on this form will only be carried out if it is necessary and is reasonable in the circumstances, in relation to the medical treatment proposed, to safeguard or promote physical or mental health.

I would like to have: **local anaesthetic throat spray** ☑
or sedation ☐ (Please tick box)

Have you ever been notified that you are at an increased risk of CJD/VCJD for public health purposes:

☐ Yes ☑ No

Consent Signature

Signed James Weir Date 22/5/2015

Name (print in capitals) JAMES WEIR

Please sign here if you refuse to consent to the emergency administration of blood or blood products.

Signed _____ Date _____

Staff Only

Confirmation of consent (to be completed by a health care professional when the patient is admitted for the procedure)

I have confirmed that the patient understands what the procedure involves including any risks.

I have confirmed that the patient has no further questions and wishes the procedure to go ahead.

Signed Mharvey Date 22.05.15

Name (print in capitals) MHAIRI HARVEY

Job Title S/N



Review May 2014

97946

MIS 241379

NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

CHI: 1203893450

Royal Alexandra Hospital

Total Att: **86**

12 Mth Att: **0**

Title: **MR**

WEIR **James Thomas**

DOB: **12/03/1989** Age: **37y** Sex: **Male**

27D MACDOWALL STREET

Johnstone
Renfrewshire
PA5 8QJ
07553015425

Next of kin: **WEIR, Deborah**
Relationship: **Sister**
07306306678

GP: **UH Rehman**
01505 321733

Attendance Date: **17/06/2026** Arrival Time: **17:20**

Registration Time: **17:20** Date of Incident: **17/06/2026**

Major Incident Desc:

Reason for Attendance: **BIBP - lac to head**

Nursing Assessment

Alerts: **Yes** Allergies: **Yes** Pain Score:

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

Presenting Complaint:

Observation Date: **17/06/2026 17:59** Nurse name: **Nurse Louise McAlpine2**

RR		bpm
Oxygen		%
Air or O2		
SpO2		%
HR		bpm
BP	/	mmHg
CRT		
MAP		mmHg
AVPU		
Temp		C
EWS Total		

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

GCS	
Eyes	
Motor	
Verbal	
Total	

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

Nursing Notes: **"BIBP - Altercation whilst under arrest, patient hit head off fence with nails in fence. Laceration to left side of forehead and haematomata to centre of forehead. No Loc, GCS 15/15 Head Injury " "SCALP HAEMATOMA "**

Child Assessment Questionnaire

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

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

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

DO NOT WRITE HERE PLEASE

ONCE ONLY PRESCRIPTIONS (including Tetanus Prophylaxis)						
Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Time of Administration	Signature	Given By
17/6/26	Co-codamol	2x30/500	PO	1809	PaD	cmb

James Thomas Weir - 1203893450.

Date	CLINICAL NOTES
	Seen by (Dr) Time seen

Date	CLINICAL NOTES

Discharge Codes (Please CIRCLE)					Discharge date	
1. Admission	2. Discharge	3. Refer to GP	4. Transfer to other (see below)			
5. Died	6. Refer to OP Clinic (see below)		7. Irregular Discharge	8. D.O.A.	Discharge time	

Ward number (if admitted):	Transfer to hospital:	Consultant If admitted):

Follow up	Arranged			Not arranged			To be arranged	
Clinic referred to	A&E	Hand injury	Fracture	Pop Check	Medical	Surgical	ENT	Others (specify):

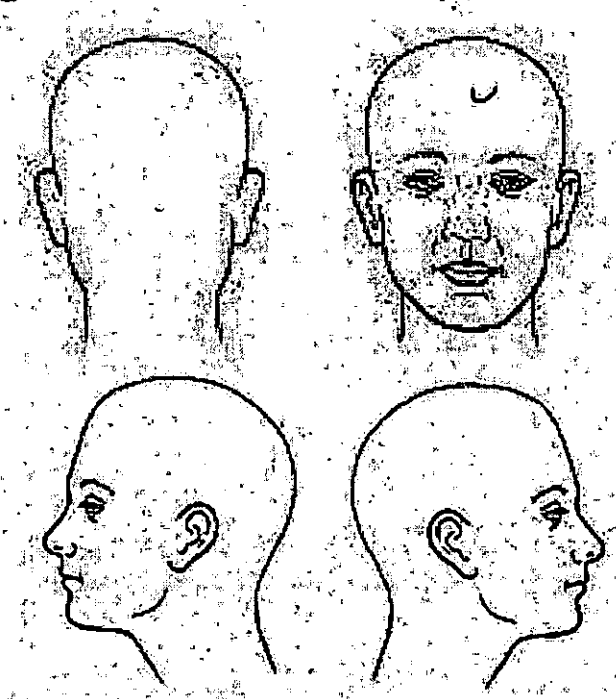
Discharge Prescription Packs

Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Frequency	Signature	Given By

1203893450 12/03/1989
WEIR
James Thomas

Lacerations, bruises, etc: indicate size in cms. *Treatment: indicate number of sutures, glue, etc*

1 cm Subcut wound to forehead
Base of wound Dermabond
wound clean & covered with wound glue



D/c to police custody

GCS when examined	E 4 /4	M 6 /6	V 5 /5	GCS 15
Lowest recorded GCS at any time (include ambulance)	E	M	V	Time

Imaging	Not needed	Done	Result
C Spine X Ray	✓		
Face X Ray	✓		
CT Brain			

Have you given:	Not needed or N/A	Yes
Tetanus Booster or course started		✓
HI Advice Card (& patient discharged)		✓

For all admitted patients:

Main Reason for admission:

	Done	Not needed
CIWA scale prescription		
IV fluids chart		
Bloods done (inc. arrangements for results)		
Compulsory for ALL admissions:		
Drug Kardex		
Neuro obs: at least two sets done in ED.		
ED card: usual admission details including PMH, drugs, general examination, etc.		

Ward Nurses please do Neuro Obs
Hourly ☐ Half Hourly ☐

Doctors Signature:

Print name: E Coulter

Royal Alexandra Hospital & Inverclyde Hospital . Form for Assessment of

HEAD INJURY

For all patients with a head injury under ED. Attach inside the ED card. For patients with anything but the simplest of presentations, other relevant information must also be recorded on the ED card.

Sticky Label or write details:

1203893450 12/03/1989
WEIR
James Thomas

Today's Date: 17/06/26
Time: 1800
Date of injury: 17/06/26
Time of injury: 1600

Mechanism of Injury:
In Police custody. Being restrained by police. Hit head off wall. Cuts to head.

	No	Unsure	Yes	
> 65 years of age	✓			
Alcohol consumption			✓	Alcohol level if measured:
Drug abuse	✓			Specify Drug if known:
Loss of Consciousness	✓			How long?
Amnesia Post Traumatic	✓			How long?
Amnesia Retrograde	✓			How long?
Seizure Since Injury	✓			Describe:
Headache	✓			Describe:
Nausea	✓			
Vomiting	✓			No of times?
Visual Disturbance	✓			Comment:
Other Neuro Symptoms	✓			If yes, describe:

PRE EXISTING DISORDERS:
Relevant to HI, such as: epilepsy, diabetes, frequent falls, dementia, other medical/mental disorders

Pre existing disorder Present?	✓			Specify if present:
Warfarin or coagulopathy	✓			

EXAMINATION	no	yes	Describe if abnormality
Neck Injury: evidence of	✓		
BOS Fracture: clinical signs of	✓		
Tympanic Membs abnormal	✓		
Vault Fracture seen or felt	✓		
Dysphasia	✓		
Vision loss	✓		
Limb Movements abnormal	✓		
Gait abnormal	✓		
Eye Movement abnormal	✓		
Behaviour abnormal	✓		
Pupils reacting abnormally	✓		
CSF leak	✓		

NHSGGC Adult In-Patient National Early Warning Sc (NEWS)

NHS Greater Glasgow and Clyde

Affix Patient ID

James Thomas Weir
1203893450

	Date	Ward	Time
Admitted			
Transferred			
Transferred			
Transferred			
Transferred			

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

Document all actions and interventions

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

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

Discontinuation of NEWS

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

Signed.....

Medical:.....

Date:.....

Glasgow Coma Scale

Pupil Reaction and Size
s = sluggish
+ = reaction
- = no reaction
o = dyel
Pupil Size (mm)

Date:
Time:
Eyes closed by swelling = NT
Endotracheal tube or tracheostomy = NT
Always record the best response
TOTAL
Right size:
Right reaction:
Left size:
Left reaction:
Record right (R) and left (L) separately if there is a difference between the two sides
Record right (R) and left (L) separately if there is a difference between the two sides

Pain Score

Ask the patient to rate his/her pain by using numerical scale 0 to 10. Use the chart below to assist the patient. If the patient is unable to communicate, use alternative pain scoring tools.

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

Pain Function Score

A	No limitations, actively unrestricted by pain or settles quickly
B	Mild limitations, mild activity restrictions
C	Moderate limitations, attempts but reluctant to continue because of pain. Seek Advice
D	Severe limitations, unable to or refuse to perform because of pain. Urgent Review Required

1203893450
Weir
James Thomas

NEWS 2 Key	1	2	3

| | | |

NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

TAU

Affix Label

Hospital (circle)	IRH	RAH	RHSC	GRI	WIG	VI	VIMIU	Stob	VOL	SGH

Title:	1203893450		Sex: M ☐ F ☐
SURNAME:	WEIR	M	Forename:
CHI:	James, T	12/03/1989	Dob: / Age:
Local address:	27D MACDOWALL STREET Johnstone, Renfrewshire PA5 8QJ		Next of kin: Relationship: Tel: GP:
Postcode:			
Tel:			Tel:

Attendance date: 30/5/25	Arrival time:	Date of incident:
Registration time:		Major incident description:
Reason for attendance:		

Affix Label

Nursing Assessment

Alerts:

Presenting complaint:

Triage category:	Pain score:	Tetanus up-to-date / fully immunised?
Allergies:		

Observations date:			Time:			Nurse's name:			
Temperature		°C	BM		mmol/L	GCS			
HR		bpm	PF		l/min	Eyes			
BP		mmHg	Expected PF		l/min	Motor			
MAP		mmHg	Weight		kg	Verbal			
RR		bpm	Height		cm	Total			
SpO_2		%	Visual Acuity			Pupils – Right		Pupils – Left	
Oxygen		%	Left	6/		Size		Size	
			Right	6/		Reaction		Reaction	
			With correction?						

Nursing Notes:

Child Assessment Questionnaire

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

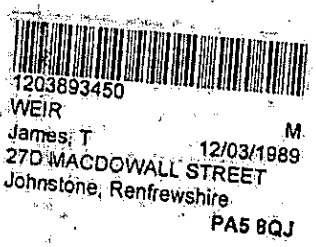
Discuss with Senior Medical Staff / Nurse on duty any factors identified

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

DO NOT WRITE HERE PLEASE

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

Date	CLINICAL NOTES	
	Seen by (Dr)	Time seen



Date	CLINICAL NOTES

Discharge Codes (Please CIRCLE)					Discharge date	
Admission	2. Discharge	3. Refer to GP	4. Transfer to other (see below)			
Died	6. Refer to OP Clinic (see below)		7. Irregular Discharge	8. D.O.A.	Discharge time	

Ward number (if admitted):	Transfer to hospital:	Consultant If admitted):

Follow up	Arranged			Not arranged			To be arranged	
Clinic referred to	A&E	Hand injury	Fracture	Pop Check	Medical	Surgical	ENT	Others (specify):

Discharge Prescription Packs

Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Frequency	Signature	Given By
3/9/23	Co-Codamol	30/500	oral	TDS		

Patient nar 1203893450
WEIR M
James, T 12/03/1989
Patient CHI 27D MACDOWALL STREET
Johnstone, Renfrewshire
PA5 8QJ

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Greater Glasgow and Clyde

Emergency Care Nursing Documentation

Initial Investigations

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

Signature:

Communication

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

Signature:

Risk Assessments and Screening Tools

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

Signature:

Pause for Discharge or Transfer

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

Signature:

Patient nam

Patient CH

1203893450
WEIR
James, T M
27D MACDOWALL STREET 12/03/1989
Johnstone, Renfrewshire
PA5 8QJ

NHS
Greater Glasgow and Clyde

Care Rounds Checklist

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

Signed _____ Name _____ Designation _____

Signed _____ Name _____ Designation _____

Signed _____ Name _____ Designation _____

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

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

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

Patient n

Patient C

1203893450
WEIR M
James, T 12/03/1989
27D MACDOWALL STREET
Johnstone, Renfrewshire
PA5 8QJ

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

NHS
Greater Glasgow and Clyde

PUDRA

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

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

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

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

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

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

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

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

Patient nam

Patient CHI

1203893450
WEIR M
James, T- 12/03/1989

NHS
Greater Glasgow and Clyde

Nursing notes cont.

Date and Time		Name/Signature

Patient nam

Patient CHI

1203893450
WEIR M
James, T 12/03/1989
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PA5 8QJ

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Ongoing Care

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

Patient name

Patient CHI

1203893450
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Greater Glasgow and Clyde

Nursing notes

Date and Time		Name/Signature
30/5/25	pt ret from Gp: Elbow Bursitis pt consulting c/v and plan. Bloods ☑ 1100 Ortho c/v ☑, discharged home. with no follow up, TTO co-codamol as prescribed	

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☐
NURSING ☐

Please tick ✔ appropriate directorate

1203893450
WEIR M
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Date & Time		Signature, Print Name & Designation
30/5/13 6:37	- olecranon bursitis (chronic) - a year - Not inflamed, tender or showing signs of local infection. - pain free ROM of elbow - swelling is a lemon size - Inflamatory markers are Normal. - Plan → pain killer has been prsc. & disch.	Kobeel.

Date & Time		Signature, Print Name & Designation

NHSGGC NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

1203893450 M
WEIR
James, T 12/03/1989
270 MACDOWALL STREET
Johnstone, Renfrewshire
PA5 8QJ

	Date	Ward	Time
Admitted			
Transferred			
Transferred			
Transferred			
Transferred			

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

Document all actions and interventions

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

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

Discontinuation of NEWS

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

Signed.....

Medical: .....

Date: .....

Glasgow Coma Scale

Pupil Reaction and size
s = sluggish
f = fixed
n = no reaction
c = eyes closed
Pupil Size (mm): 1 2 3 4 5 6 7 8

Date:
Time:
Eyes (open) by evening = NT: Spontaneously 4; To voice 3; To pain 2; None 1; NT
Verbal: Orientated 5; Confused 4; Words 3; Sounds 2; None 1; NT
Intubated tube or tracheostomy = NT: Obeys command 6; Localising pain 5; Normal flexion 4; Abnormal flexion 3; Extension 2; None 1; NT
Motor: Always record the best
TOTAL 15
Right size: Right reaction: Left size: Left reaction:
Record right (R) and left (L) separately if there is a difference between the two sides: Normal power; Mild weakness; Severe weakness; Spastic fixation; Extension; No response
Record signs (S) and symptoms (Y) separately if there is a difference between the two sides: Normal power; Mild weakness; Severe weakness; Spastic fixation; Extension; No response

Pain Score

Ask the patient to rate his/her pain by using numerical scale 0 to 10. Use the chart below to assist the patient. If the patient is unable to communicate, use alternative pain scoring tools.

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

Pain Function Score

A	No limitations, activity unrestricted by pain or settles quickly
B	Mild limitations, mild activity restrictions
C	Moderate limitations; attempts but reluctant to continue because of pain. **Seek Advice**
D	Severe limitations, unable to or refuse to perform because of pain. **Urgent Review Required**

1203893450 M
WEIR
James, T 12/03/1989
270 MACDOWALL STREET
Johnstone, Renfrewshire
PA5 8QJ

mi • 316654 v5.1 • GGC00264

NEWS 2 Key | 1 | 2 | 3

| | | |

RM 3

NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

CHI: 1203893450

Royal Alexandra Hospital

Total Att: 84

12 Mth Att: 3

Title: **MR**

WEIR **James**

DOB **12/03/1989** Age: **33y** Sex: **Male**

27D MACDOWALL STREET

Johnstone
Renfrewshire
PA5 8QJ
07553015425

Next of kin: **WEIR, Deborah**
Relationship: **Sister**
07306306678

GP: **JC Sim**
01505 321733

Attendance Date: **12/05/2022** Arrival Time: **09:20**

Registration Time: **09:20** Date of Incident: **12/05/2022**

Major Incident Desc:

Reason for Attendance: **biba chest pain**

Nursing Assessment

Alerts: **Yes** Allergies: **Yes** Pain Score:

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

Presenting Complaint:

Observation Date: **12/05/2022 09:24** Nurse name: **Nurse Irene Brown2**

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

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

GCS	
Eyes	
Motor	
Verbal	
Total	

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

Nursing Notes: **"Chest pain central chest radaring to left. hx axs ?withdrawal, hx mh hx adad. Patient has stated to sas crew he has daily sulcidal ideations, see reg with OMAR RDS. "**

Child Assessment Questionnaire

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

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

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

DO NOT WRITE HERE PLEASE

ONCE ONLY PRESCRIPTIONS (including Tetanus Prophylaxis)

Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Time of Administration	Signature	Given By
12/5/22	PARACIMOX (1+(1x2)		IV	1020		
12/5/22	GAVISCON PAEDIATRIC	20ml	O	1020		
12/5/22	CALCIUM GLUCONATE	10ml 10%	IV	1236		

Date	CLINICAL NOTES	
	Seen by (Dr)	Time seen

1203893450
WEIR M
James 12/03/1989

Date	CLINICAL NOTES

Discharge Codes (Please CIRCLE)

1. Admission 2. Discharge 3. Refer to GP 4. Transfer to other (see below)
5. Died 6. Refer to OP Clinic (see below) 7. Irregular Discharge 8. D.O.A.

Discharge date	
Discharge time	

Ward number (if admitted):	Transfer to hospital:	Consultant If admitted):

Follow up	Arranged			Not arranged			To be arranged	
Clinic referred to	A&E	Hand injury	Fracture	Pop Check	Medical	Surgical	ENT	Others (specify):

Discharge Prescription Packs

Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Frequency	Signature	Given By

Patient name

Patient CHI

1203893450
M
WEIR
James
12/03/1989
27D MACDOWALL STREET
Johnstone, Renfrewshire
PA5 8QJ

NHS
Greater Glasgow and Clyde

Emergency Care Nursing Documentation

Presenting complaint - and relevant past medical history including allergies

Date and Time		Name/Signature
12-5-22	10-00 MENTAL HEALTH ISUES	FS F SMYTH

Nursing notes - on admission

Date and Time		Name/Signature
12-5-22	10:00 PATIENT TAKEN INTO ROOM AND PREPARED FOR EXAMINATION	FS F SMYTH

Triage

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

Communication

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

Risk Assessments and Screening Tools

SEPSIS	Y	(N)	GMAWS	Y	(N)
FAST	Y	(N)	Adult Support and Protection	Y	(N)
Swallow Testing	Y	(N)	Mental Health Triage Assessment	Y	(N)
Falls Risk (clinical judgeument)	Y	(N)	Child Protection Concerns	Y	(N)

Signature:

Patient name

Patient CHI

1203893450
WEIR
James M
12/03/1989
27D MACDOWALL STREET
Johnstone, Renfrewshire
PA5 8QJ

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Greater Glasgow and Clyde

Care Rounds Checklist

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

Signed F Smyth Name F SMYTH Designation HCSW

Signed _____ Name _____ Designation _____

Signed _____ Name _____ Designation _____

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

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

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

Patient name

Patient CHI

1203893450
WEIR M
James 12/03/1989
27D MACDOWALL STREET
Johnstone, Renfrewshire
PA5 8QJ

NHS
Greater Glasgow and Clyde

Nursing notes - discharge plannning

Date and Time		Name/Signature

Outcomes and outstanding issues

Date and Time		Name/Signature

Reason for Discharge or Transfer

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

Signature:

Contact with relatives

Signature:

Patient name .....

Patient CHI .....

or use sticker

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

NHS
Greater Glasgow and Clyde

PUDRA

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

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

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

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

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

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

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

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

Patient name

Patient CHI

1203893450
WEIR
James M
27D MACDOWALL STREET 12/03/1989
Johnstone, Renfrewshire
PA5 8QJ

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Greater Glasgow and Clyde

Nursing notes - ongoing care

Date and Time		Name/Signature
15/12 12'5	GMAWS in place C/o IV Patrinex Arcit bloods	
12[illegible]	Given Calcium Gluconate for hypercalcaemia	
1225	calcium gluconate given	

Patient name .....

Patient CHI .....

or use sticker

NHS
Greater Glasgow and Clyde

4AT assessment - for delirium and cognitive impairment

		Circle Score
(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 (alert, but not agitated, through assessment) Mild sleepiness (<10 secs) after waking, then normal Clearly abnormal	0 0 4
(2) AMT4 Age, date of birth, place (name of the hospital/building), current year.	No mistakes 1 mistake 2 or more mistakes/untestable	0 1 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.	wAchieves 7 months or more correctly Starts but scores <7 months / refuses to start Untestable (cannot start, unwell, drowsy, inattentive	0 1 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 Yes	0 4

4 or more possible delirium + /- cognitive impairment
1-3 possible cognitive impairment
0 delirium or severe cognitive impairment unlikey (but delirium still possibe if (4) information incomplete

TOTAL

Frailty Assessment Tool (Healthcare Improvement Scotland)

Step 1 Would this person benefit from Comprehensive Geriatric Assessment (CGA)? circle Y or N

F	**Functional impairment**	(new or worsening) eg difficulty with self care	**Y**	**N**
R	**Resident**	in a care home	**Y**	**N**
A	**Altered mental state**	such as delirium or dementia **(4AT Assessment)**	**Y**	**N**
I	**Immobility/instability**	decline in mobility, difficulty mobilising without help, fall leading to presentation	**Y**	**N**
L	**Living at home with support**	on a daily basis (homecare, one visit or more per day)	**Y**	**N**

If YES to any of the criteria in Step 1 move to Step 2

Step 2 Would this person be better managed by another speciality team at present? circle Y or N

Clear need for other specialty input eg exacerbation of known long-term condition such as COPD	**Y**	**N**
Need for HDU/ITU (including non-invasive ventilation)	**Y**	**N**
Suspected new stroke or TIA, consider thrombolysis and care in stroke unit	**Y**	**N**
Head injury with loss of consciousness	**Y**	**N**
Acute abdominal pain/ surgical presentation	**Y**	**N**
Upper GI Bleed	**Y**	**N**
Chest pain with suspected acute coronary syndrome	**Y**	**N**
Trauma with suspected fracture	**Y**	**N**

Are any of the criteria met?

If YES to any criteria in Step 2: Prioritise move to non geriatric service as appropriate. If necessary consider geriatric advice on parent ward.

If YES to any criteria in Step 1 and NO to ALL criteria in STEP 2: Prioritise transfer of care to specialist geriatric assessment service.

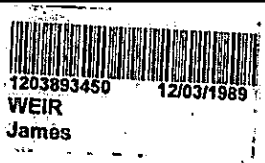
Cycle 20

NHS
Greater Glasgow and Clyde

Acute Medical Unit Admission Proforma

MAU/A&E/AMU

Royal Alexandra Hospital, Paisley/Vale of Leven Hospital/IRH

Patient Details		
Name: Address:	 	Sex: F ☐ M ☐ DoB __/__/__ Age:
Telephone:		
GP:		
Next of Kin:		
Telephone:		

Episode Details			
Date patient seen:		Time seen:	
Source of referral:	GP ☐ A&E ☐ OPD ☐ Self ☐ Other =		
Admitting Dr:		Grade	Bleep
Consultant:			

Resuscitation Decision

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

Signature: _____ Name: _____ Grade: _____

If DNA CPR → Complete appropriate form

Cycle 20

Presenting Complaint(s)	
Presenting complaint	- chest / abdo pain / alcohol XS.
History of presenting complaint	- Stabs 'years' of chest pain + RLF pain - pain in chest is left sided + described as 'squeezing' - no clear pattern - no SOB ~~or~~ cough productive of green sputum - RLF 'twisting' pain. - BO normally - ?Dysuria - dark urine - Stabs vomits daily ?haematemesis

Past Medical History / Review of Old Notes. Review eKIS if available
- alcohol XS - ADHD

Systemic Enquiry

Cycle 20

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MEDICINES RECONCILIATION – Acceptable to staple fully completed Emed Rec

Source of medication history Patient ☐ Relative/carer ☐ GP Phone call ☐ ECS ☐

(>1 source preferred) Patient own drugs ☐ Com. Pharmacist ☐ GP letter/summary ☐ Repeat Script ☐

Other (please specify) .....

Admission Medicines Dose / Frequency	Plan for medicines (Dr complete) Continue / Amend / Withold / Stop	Comments Reason for alteration

Staple emed-rec to this page

Allergies	List any over-the-counter or alternative medicines
None known ☐ MCR4	
	Do medicines need further clarification ? Yes ☐ No ☐
List collected by :	**Plan approved by :**
Designation : Date :	Designation : Date :

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

Cycle 20

Social History

Smoking History

Ex-smoker/Smoker ____cpd ___yrs Never smoked

Alcohol History drank 3 bottles of wine last night - unsure how much he drinks normally

____ Units/week FAST score if excess _____

Recreational Drugs Driving Status

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

Family History

Observations

RR: bpm **Sats:** % **FiO2:** **Temp:** °C **BP:** / **HR:** bpm **BM:**

General Examination

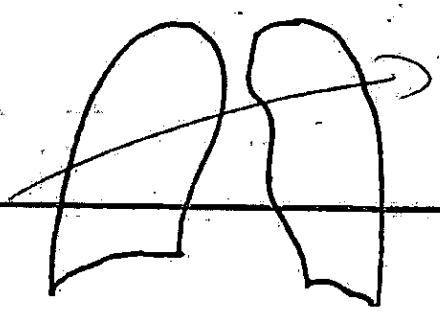
General Appearance:

- ~~frail~~
- doesn't appear to be withdrawing

Cyanosis / pallor / jaundice / clubbing / lymphadenopathy

Respiratory

PEFR =



Cycle 20

Cardiovascular

Pulse **Heart Sounds** I + II + 0

JVP

Oedema

Peripheral Pulses **cap refill**

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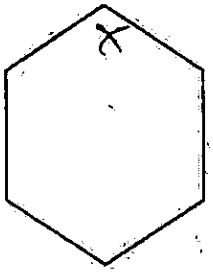
Gastrointestinal system

Masses:

Organomegaly:

Bowel sounds:

PR:



- soft abdomen
- tender epigastrium
- BS ✓
- no masses

Neurological system

GCS: /15 **E: /4** **M: /6** **V: /5** **AMT: /4** (AMT 4 = age, time, place, year)

Pupils/fundoscopy:

Cerebellar and extrapyramidal:

Cranial Nerves:

Neck:

	RUL	LUL	RLL	LLL
Tone				
Power				
Co-ordination				
Reflexes				
Sensation				

Gait:

Locomotor

	Tender	Swollen	Deformity	Which joint?
Arms				
Legs				
Spine				

Cycle 20

Investigations

- bloods
- ECG
- CXR

(Differential) diagnosis

- gastritis
- pancreatitis
- chest pain does not sound cardiac

Management Plan

- ↑ bloods / CXR (N) (U) c̄ ↑ F/U as planned
- ? Navigator referral - declined
- Bloods - mild hypercalcaemia - replaced. Trop (-).
- wants an alcohol detox

Thromboprophylaxis assessed ☐ **Medicine Reconciliation** ☐ **DD6 if required** ☐

Signature [signature] **PRINT NAME** C [illegible] **Page:**
PRINT GRADE CMS

Senior/Medical review

- on waiting list for Keshaw unit
- states constantly has suicidal thoughts + has for years
- not acted on these thoughts
- seen recently by ↑
- has a support worker who he will contact on discharge
- wants to go home as not being offered IP detox
- agreed. Advised to keep drinking alcohol to prevent withdrawal.

[signature]

Admission checklist

Investigations reviewed ☐ **Kardex** ☐ **eKIS reviewed** ☐
Thromboprophylaxis assessed ☐ **Medicine Reconciliation** ☐ **DD6 if required** ☐

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

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

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

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Surgical patients start here

Non-operative [mainly medical] patients start here

Is the patient bed-bound or expected to have reduced mobility relative to normal state for ≥ 3 days?

Yes ☐ No ☐

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

Age >60	☐	Use of oestrogen-containing contraceptive therapy	☐
Active cancer or cancer treatment	☐	Use of hormone replacement therapy	☐
Dehydration	☐	Pregnancy or < 6 weeks post partum [seek specialist advice]	☐
Known thrombophilias	☐	Critical care admission eg HDU/ITU	☐
Obesity (BMI>30)	☐	Total anaesthetic + surgical time >90 minutes	☐
Current significant medical condition e.g. Serious infection, Heart failure, Respiratory disease or inflammatory disease	☐	Surgery involving pelvis or lower limb with a total anaesthetic + surgical time >60 minutes	☐
Personal history or first degree relative with a history of VTE	☐	Acute surgical admission with inflammatory or intra-abdominal condition	☐
Varicose veins with phlebitis	☐	Hip fracture	☐

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

Yes, 1 or more risk factors identified ☐

No risk factors identified ☐

Does the patient have any contraindications to pharmacological prophylaxis? (tick √ all that apply)

Active bleeding	☐	Untreated inherited bleeding disorders (e.g. haemophilia or von Willebrands)	☐
Acquired bleeding disorders (e.g. acute liver failure)	☐	Neurosurgery, spinal or posterior eye surgery	☐
Concurrent use of anticoagulants (such as warfarin with INR>2)	☐	Lumbar puncture, epidural/spinal anaesthesia expected within the next 12 hours	☐
Acute stroke	☐	Other procedure with high bleeding risk – discuss with senior if unsure	☐
Uncontrolled hypertension (230/120 mmHg or higher)	☐	Lumbar puncture, epidural/spinal analgesia within the previous 4 hours	☐
Thrombocytopenia (<75 x 10^9/l)	☐	Thyroid surgery	☐

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

No contraindications to pharmacological prophylaxis identified ☐

Contraindications to pharmacological prophylaxis identified ☐

Surgical patients – Enoxaparin 40mg + AES ☐*
*prior to application of AES, please check contraindications to AES
Medical patients – Enoxaparin 40mg ☐
Prescribe Enoxaparin at 6pm
[on day of surgery, at the later of either 4h post-op or 6pm]
Reduce Enoxaparin to 20mg if <50Kg or eGFR <30ml/minute/1.73m² ☐
Discontinue at discharge or when returned to pre-morbid mobility

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

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

Risk assessment result – please tick √ all that apply

VTE risk factors: YES ☐ NO ☐ Contraindications to pharmacological prophylaxis: YES ☐ NO ☐ Prescribed: LMWH ☐ AES ☐ NONE ☐

Patient informed of VTE risks and benefits of thromboprophylaxis YES ☐ NO ☐ N/A ☐ Information leaflet provided YES ☐ NO ☐

Print Assessor's Name: _____ Signature: _____ Date: _____

DD6 **All patients over 64**

4AT	Y/N/Na
Carers involved	Y/N/Na
Med rec	Y/N/Na
Sepsis Screen	Y/N/Na
Resuscitation status considered	Y/N
Discharge planning	Y/N/Na

Sepsis Six

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

Cycle 20

Results

Baseline	Date Time									
	Parameter	Ref Range								
	Hb	130-180								
	WCC	4.0-11.0								
	Plts	150-400								
	MCV	78 - 99								
	Neut	2.0 - 7.5								
	PT	9.0 - 13.0								
	APTT	27.0 - 38.0								
	Fibrinogen	1.5-4gm/L								
	INR	( )								
	Thromb T	11-15 secs								
	D-Dimer	<230								
	ABG/VBG									
	Na^+	135 - 145								
	K^+	3.5 - 5.0								
	Cl^-	97 - 107								
	HCO_3^-	23 - 30								
	Urea	2.5 - 7.5								
	Creat	62 - 124								
	eGFR									
	Glucose	3.5 - 5.9								
	Protein	32 - 82								
	Albumin	37 - 50								
	AlkP	33 - 117								
	Bil	0.5 - 19								
	ALT	11 - 55								
	AST	13 - 42								
	GGT	8-60								
	ESR									
	CRP	<3								
	Troponin I hs	Men 0 - 34 Women 0 - 16								
	CK	23 - 190								
	Corr Ca^{++}	2.25 - 2.60								
	PO_4^-	0.8 - 1.4								
	Mg^{++}	0.7 - 1.1								
	Digoxin	0.5 – 2.0								
	Alcohol									
	Paracetamol	<100 @4 hr								
	Salicylate									
	Amylase	<100								
	LDH	240 - 480								
	Folate	3.1 - 20								
	B12	200 - 900								
	Ferritin	15 - 200								
	TSH	0.35 – 5.00								
	T4	9 - 21								
	Urinalysis									

DON'T MISS AKI Checklist within 24 hrs of admission

D Dipstick Urine: _____

O Obtain Ultrasound: Yes ☐ N/A ☐
(Stage 2/3: within 24 hours of Admission)

N Need for Catheter: Long-term ☐ Yes ☐ No ☐ Refused ☐

T Team Renal to contact: Considered ☐ Done ☐ N/A ☐ _____

M Medicine Reconciliation: ☐

I Intravenous Fluids: Yes ☐ Contraindicated ☐

S Suspected Cause: _____

S Staging of AKI: (Tick Box Below)

☐ 1 (RISK if: Creatinine X 1.5)
☐ 2 (INJURY if: Creatinine X 2)
☐ 3 (FAILURE if: Creatinine X 3)
(compared to baseline)

Signature/Name/Grade_____

Cycle 20

Post Take Ward Round AMU/MAU/OAAU

Consultant: ..... **Date:** ..... **Time:** .....

Summary

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Temp:

Pulse:

BP:

Sat O2:

FiO2:

RR:

ECG:

Bloods:

CXR:

Other investigations:

Imp:

Plan:

AWI considered ☐ Thromboprophylaxis need reviewed ☐ Medicine reconciliation complete ☐
If cardiac or respiratory arrest is considered a possibility for the patient has CPR status been reviewed and documented Yes ☐ No ☐
CPR decision discussed with patient Yes ☐ No (document why) ☐ Advanced directive in situ ☐ Treatment escalation plan (circle) Ward/HDU/ITU
Family informed of CPR/escalation status? – Needs discussed at first opportunity ☐ Has been discussed ☐ Patient does not want family informed ☐

Recommended Destination: _____
Suitable to board <u>if required</u> Yes ☐ No ☐
Expected Date of Discharge: _____

Signature: _____
Designation: _____
Bleep Number: _____

Cycle 20

Junior/Senior additional notes, communications with relatives.

NOTES

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NOTES

Glasgow Assessment and Management of Alcohol

Please Attach Patient Label

1203893450

CHI:____ WEIR M

Name:__ James 12/03/1989

Address: 27D MACDOWALL STREET
Johnstone, Renfrewshire
PA5 8QJ

Postcode:_____

Estimated Weekly Alcohol Units : _____
Daily Units x Number of Days per Week)
Excessive Weekly Consumption >*14 units/week*

Estimated Date / Time Of Last Drink: _____
(If ≥ 5 Days, Re-consider Alcohol Withdrawal Status)

Presents with or has had previous alcohol withdrawal seizures/ severely agitated withdrawal:

YES: ☐ NO: ☐

IS IT ALCOHOL WITHDRAWAL?

Consider alternative diagnoses such as delirium, encephalopathy, traumatic brain injury especially if symptoms atypical or prolonged (≥5 days since last alcohol)

Fast Alcohol Screening Tool - FAST:

Note : 1 drink = 1 unit of alcohol

1. MEN: How often do you have EIGHT or more drinks on one occasion?
   WOMEN: How often do you have SIX or more drinks on one occasion?

   Never ☐0 Less than monthly ☐1 Monthly ☐2 Weekly ☐3 Daily or almost daily ☑4

2. How often during the last year have you been unable to remember what happened the night before because you had been drinking?

   Never ☐0 Less than monthly ☐1 Monthly ☐2 Weekly ☐3 Daily or almost daily ☑4

3. How often during the last year have you failed to do what was normally expected of you because of drinking?

   Never ☐0 Less than monthly ☐1 Monthly ☐2 Weekly ☐3 Daily or almost daily ☑4

4. In the last year has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down?

   No ☐0 Yes, on one occasion ☐2 Yes, on more than one occasion ☑4

Score of 3 or more: FAST Positive

Total 16

FAST Positive? Yes ☐ No ☑

FAST 0-2:	**Negative: No action required.**
FAST 3-8:	**Hazardous Drinking: Advise regarding safe drinking levels and offer information leaflet / advice.**
FAST 9-16:	**Probable Dependent Drinking: Advice as above and consider referral to Addiction Liaison Service.**

EXCEPTIONAL PATIENT GROUP WITH CO-MORBIDITY?

Be aware of Patients with Co-morbidities presenting with features of Alcohol Withdrawal, especially:

- Patients with evidence of liver disease: especially jaundice, encephalopathy
- Patients with other co-morbidity (ie COPD, pneumonia, cerebrovascular disease, reduced GCS, elderly >70, head injury, pregnancy)

REFER TO SECTION 3 (PAGE 3) FOR MANAGEMENT ADVICE

PLEASE INSERT IN PATIENT'S CASE RECORD ON COMPLETION OF TREATMENT

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Order Number GGC0169

Prophylaxis and Treatment of Wernicke-Korsakoff Syndrome

The guidance applies to all alcohol use disorders; hazardous, harmful and dependent.

ASSESS FOR WERNICKE'S ENCEPHALOPATHY
Does the patient have any of the following signs/ symptoms?

- Confusion
- Ataxia
- Decreased consciousness
- Opthalmoplegia
- Nystagmus
- Hypothermia/ hypotension

YES → Presumptive diagnosis of Wernicke's Encephalopathy (if symptoms otherwise unexplained) **GO TO BOX A**

NO → Assess Risk of Wernicke's Encephalopathy **GO TO BOX B**

BOX A	Day 1-2	Day 3-5	Day 6 onwards
	Pabrinex IV:	**Pabrinex IV/IM**	Change to **oral**
Presumptive Diagnosis of Wernicke's Encephalopathy: This requires URGENT treatment	2 pairs of vials three times a day. **Magnesium** Check Serum Magnesium URGENTLY and give intravenous replacement if deficient.	1 pair of vials three times a day	**Thiamine** 50mg four times a day **or** continue IV/IM **Pabrinex** at discretion of Medical Team

BOX B

Assessment of Risk of Wernicke's Encephalopathy

RISK FACTORS for WERNICKE'S	
Risk Factors	**Severe Risk Factors**
Weight loss (MUST=1)	Severe Weight loss (MUST≥2)
Poor diet or vomiting for <5 days	Poor Diet or vomiting for >5 days
Alcoholic Liver Disease	
Presents with Seizure	
Age ≤18 or ≥65	

No Risk Factors	One Risk factor	Two or more Risk Factors or any single Severe Risk Factor
Oral Thiamine 50mg four times a day	**Pabrinex IV/IM** 1 pair of vials three times a day for **24** hours then change to **oral Thiamine** 50mg four times a day	**Pabrinex IV/IM** 1 pair of vials three times a day for **48** hours then change to **oral Thiamine** 50mg four times a day

Check Magnesium in all patients and correct deficiency

Important notes

- If oral thiamine is indicated but a patient is unable to take medicines by mouth, then consult your ward pharmacist: NG administration may be possible or IM Pabrinex® (1 pair of vials once daily) are alternatives
- Intravenous Pabrinex® should be administered over 30 minutes
- Anaphylaxis is a rare complication of IV Pabrinex® administration and even more uncommon with IM administration. Monitor patient for wheeze, tachycardia, breathlessness and skin rash. Facilities for the administration of adrenaline and other resuscitation should be available.
- Additional vitamin supplementation as clinically indicated by responsible medical team in the context of a general nutritional assessment.
- Discontinuation of oral thiamine should be considered for patients who have been abstinent for 3 months and who have an adequate dietary intake.

Management of Alcohol Withdrawal Syndrome

1. DEPENDENT DRINKING ON SCREENING - HIGH RI



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EXCEPTIONAL PATIENT GROUP WITH CO-MORBIDI

- Patients with evidence of liver disease: especially jaundice, enceph
- Patients with other co-morbidity (ie COPD, pneumonia, cerebrovas GCS, elderly >70, head injury, pregnancy)

S

NO

1. DEPENDENT DRINKING ON SCREENING - HIGH RISK

Any 2 of the following:
Presents with or has had previous withdrawal seizures or severely agitated withdrawal
High screening score (FAST ≥12)
High initial symptom score (GMAWS ≥4)

YES → **FIXED DOSE TREATMENT (Section 2) PLUS SYMPTOM TRIGGERED TREATMENT (GMAWS)**

NO → **SYMPTOM TRIGGERED TREATMENT (GMAWS)**
For exceptional patient groups see Section 3

2. FIXED DOSE TREATMENT REGIME: Oral Diazepam (see **Section 5** for patients unable to tolerate oral):

INITIAL DOSE: 20mg Diazepam 6 hourly

REDUCE DOSE: If after 24 hours no additional symptom triggered treatment has been required

OR

If after ≥48 hours of treatment GMAWS less than 4

REDUCING DOSE: (Not to be prescribed 24hrs in advance. Step down only if GMAWS remains less than 4)

15mg Diazepam 6 hourly for 24 hours
10mg Diazepam 6 hourly for 24 hours
5mg Diazepam 6 hourly for 24 hours
5mg Diazepam 12 hourly for 24 hours

3. EXCEPTIONAL PATIENT GROUPS: SYMPTOM TRIGGERED TREATMENT ONLY

- Patients with evidence of liver disease especially jaundice or encephalopathy: use oral **Lorazepam** in a symptom triggered fashion: 1-2 mg (up to 12mg in 24 hours, when senior medical review is required as below)
- Patients with other co-morbidity (i.e. COPD, pneumonia, cerebrovascular disease, reduced GCS, elderly (>70), head injury): use Lorazepam as above **OR** Diazepam at 50% of standard GMAWS dose
- In pregnancy use Diazepam at 50% of standard GMAWS dose with senior medical review if more than 30mg required in 24 hours

REVIEW PRESCRIPTION if patient is excessively drowsy
SENIOR MEDICAL REVIEW (ST3 or above) REQUIRED for diagnostic review and possible adjunctive therapy (Section 4): - If patient requires more than 120mg Diazepam in 24 hours
- If patient still requiring full dose treatment 96 hours after last alcohol ingestion

4. SEVERE WITHDRAWAL (aggressive/ uncontrollable/ dangerous behaviour)[1]

- Intravenous Diazemuls up to 40mg over first 30 minutes (up to 2mg/minute; flumazenil to be available) **(Section 5)**
- Adjunctive therapy with Haloperidol 2-5mg IM in first instance and response assessed **(refer to alcohol withdrawal section in the GGC Therapeutics Handbook regarding Haloperidol and patients with prolonged QTc)**
- Consultation regarding intensive care support may be necessary in extreme situations

5. PATIENTS UNABLE TO TOLERATE ORAL MEDICATION / PARENTERAL BENZODIAZEPINES

- Patients unable to tolerate oral medication may receive parenteral therapy as an alternative at 50% of the oral dose in the first instance, and response assessed
- Intravenous benzodiazepines should be administered by an experienced member of medical (FY2 or above) or nursing staff who have completed the appropriate Competency Training to administer IV sedation

6. MONITORING

- All patients should be closely observed for signs of over-sedation with regular observations
- Exceptional Patient Groups **(Section 3)**, patients with Severe Withdrawal **(Section 4)** and patients requiring parenteral sedation **(Section 5)** require close monitoring (NEWS) ideally with one-to-one nursing care

NHSGGC Guideline for use of Intramuscular Medication for Acutely Disturbed Behaviour in Mental Health and Associated Services

Glasgow Modified Alcohol Withdrawal Scale (GMA **Treatment Optio** GMAWS Only ☐ GMAWS & Fixed Dose ☐

Date	14/6/22																		
Time	12:10																		
Tremor 0) No tremor 1) On movement 2) At rest	0																		
Sweating 0) No sweat visible 1) Moist 2) Drenching sweats	0																		
Hallucination 0) Not present 1) Dissuadable 2) Not dissuadable	0																		
Orientation 0) Orientated 1) Vague, detached 2) Disorientated, no contact	0																		
Agitation 0) Calm 1) Anxious 2) Panicky	0																		
Score	0																		
Treatment	N.L																		
Staff Signature	[signature]																		

Score: (Do not use scoring tool if patient intoxicated, must be at least 8 hours since last drink.)

0 :Repeat Score in 2 hours (Discontinue after scoring on 4 consecutive occasions, except if less than 48hrs after last drink)

1 – 3 :Give 10mg Diazepam: Repeat Score in 2 hours

4 – 8 :Give 20mg Diazepam : Repeat Score in 1 hour

9 – 10 :Give 20mg Diazepam : Repeat Score in 1 hour

EXCEPTIONAL PATIENT GROUPS: SYTMPTOM TRIGGERED TREATMENT
Patients with evidence of liver disease especially jaundice or encephalopathy: use oral **Lorazepam** 1-2 mg
Patients with other co-morbidity (i.e. COPD, pneumonia, cerebrovascular disease, reduced GCS, elderly (>70), head injury): use Lorazepam as above **OR** Diazepam at 50% of standard GMAWS dose.
In pregnancy use Diazepam at 50% of standard GMAWS

PATIENTS MAY REQUIRE TO BE WOKEN FOR CONTINUING ASSESSMENT

CO-EXISTING ILLNESS MAY AFFECT SCORE: SEEK MEDICAL ADVICE IF IN DOUBT

FIXED DOSING & SYMPTOM TRIGGERED DOSING MUST BE NO LESS THAN 1 HOUR APART

All patients should have regular observations documented. Patients receiving high doses of Diazepam should be assessed regularly for over sedation. If a patient requires more than 120 mg of diazepam or 12 mg of lorazepam in 24 hrs a senior medical review and consideration of adjunct therapy (Section 4) is required

APPROXIMATE ORAL BENZODIAZEPINE EQUIVALENCE: 10mg Diazepam = 1mg Lorazepam = 25mg Chlordiazepoxide
Patients should not be discharged on regular benzodiazepine

Developed by the Acute Alcohol Screening & Withdrawal Management Guideline Group. Chaired by Dr Ewan Forrest, Consultant Physician and Gastroenterologist, GRI
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Published: August 2020
Review Date: January 2023
Version: 5th Edition Amendment

Patient Information

JAMES WEIR

Age/Gender:	33y Old Male
Address:	FLAT D FLAT D 27 MACDOWALL STREET JOHNSTONE,PA5 8QJ
DOB:	12/03/1989
CHI:	1203893450
Ethnicity:	

Date:	12/05/2022
Incident Number:	CR008661902
Incident Type:	EMG
Incident Location:	FLAT D FLAT D 27 MACDOWALL STREET JOHNSTONE, PA5 8QJ

1203893450
WEIR M
James 12/03/1989

Presenting Complaint

NHS24 CALL CHEST PAIN

Additional Comments

33 yom complaining of chest pain O/A pt was sitting upright on sofa, good colour and alert chatting to crew but did seem upset. Pt stated that they were alcohol dependant and experiencing withdrawl symptoms such as hot/cold sweats, seeing black dots and pain in centre of chest radiating to left side. Pt stated that they drink at least 3 bottles buckfast a day but has had nothing to drink from 5pm yesterday 11/05/2022. Pt states that they are not coping and want to stop drinking. Pt does have contact with group called OMAR RDS and in touch once a week but feels they need further support. pt states they have ADHD. O/E pt obs were within range and 12 lead ECG is sinus rhythm.

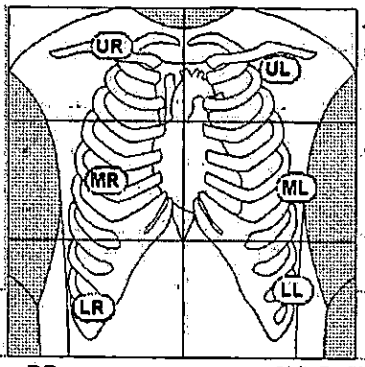
PATIENT ASSESSMENT

ACVPU Alert <C> No

A Clear

B Breathing Adequately Yes Respiratory Rate 18 SPO2 96

Oxygen Given No

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

C

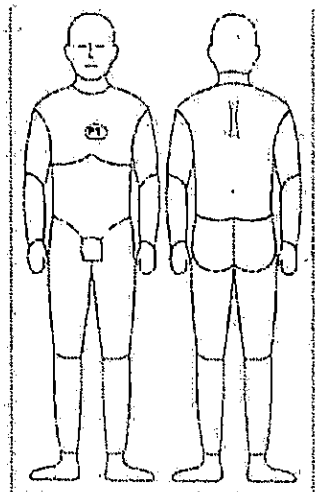
Pulse Rate	BP	Cap Refill	ECG Rhythm
104	137/73	<=2 Secs	Sinus Rhythm

Rhythm	Arm	Central/Peripheral	ECG
Reg	Right	Central	12 Lead

D

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

E



Pain

ID	Body Part	Pain Scale
P1	Chest	7

1203893450
WEIR, James
M
12/03/1989

Observations

Time	P	RR	BP	SpO2	CR	GCS	ACVPU	ETCO2	T	BM	ECG	P(L)	P(R)	PEF	CrewID
08:42	90		126/91	98											E9883009
08:34	104	18	137/73	96	<=2 Secs	15	Alert		37.6	5.6	Sinus Rhythm	3	3		E9883009

NEWS2

Time	RR	SpO2 Scale 1	SpO2 Scale 2	Air/O2	BP	P	ACVPU	T	Total
08:34	18 (0)	96 (0)		0	137 (0)	104 (1)	Alert (0)	37.6 (0)	1

HISTORY

AMPLE

Allergies	None
Medication	METHYLPHENIDATE MIRTAZAPINE THIAMINE OLANZAPINE
Past Medical History	
Overdose	UnknownWhen:UNKNOWN BUT HAS ADMITTED ATTEMPTED NUMEROUS TIMES PARACETAMOL
Suicide Attempts	UnknownWhen:ADMITTED THAT ATTEMPTED TO HANG HIMSELF A FEW TIMES
Last Eaten	>4 Hours Ago
Events Prior	WAS IN HOUSE AND TRIED TO SLEEP BUT COULDNT

Social History

Lives alone	Yes	**Patient Occupation**	Unemployed

Patients General Appearance	Normal
Living Arrangement	SISTER TAKES PT SHOPPING AND HELPS CLEAN HOUSE
Patient Mobility	Fully Mobile
Patient Communication	No Help Required
Patient Clinical Risk Factors	Alcohol
Patient Enviromental Risk Factors	None Identified

CLOSE RECORD

Treatment On Scene Non Emergency

Conveyance

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

NHS Greater Glasgow

1203893450
Patient nam WEIR
CHI James M
37D MACDOWALL STREET 12/03/1989

Part One - Nursing Triage
triage nurse to complete this page

Triage Observations
document physiological measurements

GCS	BM	HR	BP	RR	SaO^2	Temp

accompanied by
name, relationship, particular concerns

BB

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

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

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

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

Outline of Presentation
tick all the categories which apply

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

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

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

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

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

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

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

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

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

Any responses in the first column
High Risk

Other patients can be categorised as
Moderate Risk

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

name/grade TRENT Brown SV

signature

date and time 12/5/22 0935

© NHSGG&C Mental Health and Acute Services Interface Group.

NEWS 2 Key	1	2	3

| | | |

NHSGGC NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

12/03/3450 12/03/1989
WEIR
James

	Date	Ward	Time
Admitted			
Transferred			
Transferred			
Transferred			
Transferred			

Sp02 Scale 1 Target >96%
Signature:
Print Name:
Dr/ANP Initials ONLY:
Date:

Sp02 Scale 2 Target 88-92%
Signature:
Print Name:
Dr/ANP Initials ONLY:
Date:

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

Document all actions and interventions

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

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

Discontinuation of NEWS

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

Signed.....

Medical: .....

Date: .....

Glasgow Coma Scale

| | | |

NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

Minor

CHI: 1203893450

Royal Alexandra Hospital

Total Att: 83

12 Mth Att: 2

Title: **MR**

WEIR **James**

DOB **12/03/1989** Age: **33y** Sex: **Male**

27D MACDOWALL STREET

Johnstone
Renfrewshire
PA5 8QJ
07553015425

Next of kin: **WEIR, Deborah**
Relationship: **Sister**
07306306678

GP: **JC Sim**
01505 321733

Attendance Date: **21/04/2022** Arrival Time: **12:50**

Registration Time: **12:50** Date of Incident: **21/04/2022**

Major Incident Desc:

Reason for Attendance: **cut on left hand**

Affix Label

Nursing Assessment | Alerts:

Nursing Assessment

Alerts: **Yes** Allergies: **Yes** Pain Score:

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

Presenting Complaint:

Observation Date: **21/04/2022 13:14**

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

Nurse name: **Nurse Michelle McMillan**

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

GCS	
Eyes	
Motor	
Verbal	
Total	

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

Nursing Notes: **cut to left and 1/7 ago**

Child Assessment Questionnaire

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

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

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

DO NOT WRITE HERE PLEASE

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

Date	CLINICAL NOTES
	Seen by (Dr) BARRIE (AS) Time seen 16:00
21/4/22	RC:- Lac^ (L) hand
	HDC:- Pt fell onto glass which broke → lacerating (L) hand
	- ?FB in wound
	- Applied dry dressing

1203893450 12/03/1989
WEIR
James

Ex:



small flap
lac^ (L) thenar eminence
No obvious FB seen
°N/V deficit

Imp: ∴ ?FB
- Lac^ (L) hand

PLAN: XR to exclude FB → NBI
- Wound cleaned
- Steristrips / dressing applied
- (D)

RB

Date	CLINICAL NOTES

Discharge Codes (Please CIRCLE)						Discharge date	
1. Admission	2. Discharge	3. Refer to GP	4. Transfer to other (see below)				
5. Died	6. Refer to OP Clinic (see below)		7. Irregular Discharge	8. D.O.A.		Discharge time	

Ward number (if admitted):	Transfer to hospital:	Consultant If admitted):

Follow up	Arranged			Not arranged			To be arranged	
Clinic referred to	A&E	Hand injury	Fracture	Pop Check	Medical	Surgical	ENT	Others (specify):

Discharge Prescription Packs

Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Frequency	Signature	Given By

7a

NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

CHI: 1203893450

Royal Alexandra Hospital

PNA.

Total Att: 82

12 Mth Att: 1

Title: MR

WEIR

James

DOB 12/03/1989 Age: 33y Sex: Male

27D MACDOWALL STREET
Johnstone
Renfrewshire
PA5 8QJ
07572 333 730

Next of kin: WEIR, Deborah
Relationship: Sister
07306306678

GP: JC Sim
01505 321733

Attendance Date: 19/04/2022 Arrival Time: 01:23

Registration Time: 01:23 Date of Incident: 19/04/2022

Major Incident Desc:

Reason for Attendance: Unconscious - BIBA

Affix Label

Nursing Assessment

Alerts: Yes Allergies: Yes Pain Score:

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

Presenting Complaint:

Observation Date: 19/04/2022 01:24 Nurse name: Nurse Donna George

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

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

GCS	
Eyes	
Motor	
Verbal	
Total	

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

Nursing Notes: "Member of public concerned James was un-conscious. Fully alert in triage and with crew. ?sleeping in close ? seizure gcs 15/15 pearl. c/o lower back pain. Known epilepsy and daily drinker. "

Child Assessment Questionnaire

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

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

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

DO NOT WRITE HERE PLEASE

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

Date	CLINICAL NOTES
19/4/22	Seen by (Dr) L BIRCH GPST2 Time seen 0330

1203893450 12/03/1989
WEIR
James

330♂

found in flat close. ?unconscious.
Pt states coming back from pub & next remembers waking up surrounded by SAS.
Thinks was asleep.

PMH
Alcohol dependence
EUPD
PTSD
ADHD
Prev alcohol withdrawal seizures

Crying - states pain in Ⓛ flank for 2-3/52.
Unclear hx - ?infrequent bouts of pain. Denies all other symptoms - palps, sob, chest pain, urinary symptoms
Worse on movement.

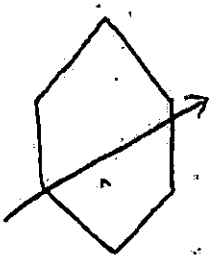
2 recent bereavements - Dad (last year) + Uncle (8 wks ago). feels depressed, denies current suicidal ideation + thoughts of self harm. Prev self harm (cuts to forearms) but nil previously.

Drinks 3x bottles wine daily. Experiences withdrawal after 6-8 hours. Last drink ~6 hours ago.
Lives alone. Has support from sister (Debbie)
Smokes cannabis most days - last smoked yesterday am
Denies other illicit drug use.

NEWS0.
OE; Crying. GCS 15/15



Clear
HS = I + II + 0

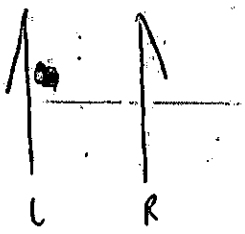


Abdo SNT.
Calves SNT.

Some mild tenderness Ⓛ paraspinal muscles



Date	CLINICAL NOTES



No spinal tenderness.

No evidence of alcohol withdrawal at present - pt in agreement.

WCC 7.9 Urea 143 Cr 61 Amylase 115.
Hb 142 eGfR >60 CRP <1

Re-examined; mild epigastric tenderness on maximal/ deep palpation

D/W surgical on-call, Dr Scott Knight, advises would not treat for pancreatitis, in view of minor tenderness + mild Amylase ↑.

Long conversation with James re alcohol use. Engaging with ARDS - has follow-up in place. Keen to cut down use, aware not to stop drinking suddenly.

Happy fit for d/c with above ARDS follow-up.

Feel pain likely msk in nature - wsg re sob, palps, LOC etc

LBirch

Discharge Codes (Please CIRCLE)				Discharge date	
1. Admission	2. Discharge	3. Refer to GP	4. Transfer to other (see below)		
5. Died	6. Refer to OP Clinic (see below)	7. Irregular Discharge	8. D.O.A.	Discharge time	

Ward number (if admitted):	Transfer to hospital:	Consultant If admitted):

Follow up	Arranged		Not arranged				To be arranged
Clinic referred to	A&E	Hand injury	Fracture	Pop Check	Medical	Surgical	ENT	Others (specify):

Discharge Prescription Packs

Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Frequency	Signature	Given By

Patient Information		Date:	19/04/2022
JAMES WEIR		Incident Number:	CR008581448
Age/Gender:	33 years 1 months 7 days Old Male		
Address:	FLAT D 27 MACDOWALL STREET JOHNSTONE,PA5 8QJ	Incident Type:	EMG
DOB:	12/03/1989	Incident Location:	IN THE CLOSE 2ND LANDING AS COME INTO CLOSE FLAT D 27 MACDOWALL STREET JOHNSTONE PA5 8QJ
CHI:			
Ethnicity:			

1203893450 12/03/1989
WEIR
James

Presenting Complaint

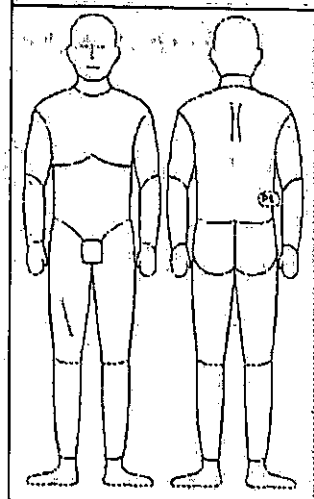
UNCONSCIOUS

Additional Comments

999 call to unknown male unconscious in flat close, found by a neighbour. Oa paramedic from sort was on scene and obtained pt name. while achieving obs pt woke up, obs as below, all in normal range. Pt stated he doesn't know what has happened, declared he is alcohol dependant and suffers with seizures. Also states that while unconscious he could hear everything. Pt states his quality of life is getting worse. States he does have an alcohol worker but doesn't see them often enough. Pt has lower right back pain which he has had for over a week, feels this is constant and wont go away and thinks this pain is related to alcohol consumption. Pt has mental health issues, hasn't grieved from losing dad and uncle.

PATIENT ASSESSMENT

ACVPU	Alert		<C>	No			
A	Clear						
B	Breathing Adequately	Yes	Chest Signs/Sounds	DIDNT AUSCILTATE			
	Respiratory Rate 18	SPO2 97	Oxygen Given	No			
C	Pulse Rate	BP	Cap Refill	ECG Rhythm			
	83	123/85	<=2 Secs				
	Rhythm	Arm	Central/Peripheral	ECG			
	Reg	Right	Peripheral				
D	GCS	Eyes	Voice	Motor	PEARL		
	15	Spontaneously (4)	Orientated (5)	Obeys Commands (6)	Yes		
E							



Pain

ID	Body Part	Pain Scale
P1	Back Body	7

Observations

Time	P	RR	BP	SpO2	CR	GCS	ACVPU	ETCO2	T	BM	ECG	P(L)	P(R)	PEF	CrewID
00:46	83	18	123/85	97	<=2 Secs	15	Alert		36.4	6.9					E9886793

NEWS2

Time	RR	SpO2 Scale 1	SpO2 Scale 2	Air/O2	BP	P	ACVPU	T	Total
00:46	18 (0)	97 (0)		0	123 (0)	83 (0)	Alert (0)	36.4 (0)	0

HISTORY

AMPLE

Allergies	None
Medication	ANTI DEPRESSANTS
Past Medical History	ADHD
Last Eaten	Unknown
Events Prior	AT FRIENDS HOUSE DRINKING

1203893450 12/03/1989
WEIR
James

Social History

Lives alone	Yes	Patient Occupation	Does Not Work

Patients General Appearance	Malnourished
Patient Mobility	Fully Mobile
Patient Communication	No Help Required
Patient Clinical Risk Factors	Alcohol
Patient Enviromental Risk Factors	WASNT IN PATIENTS HOUSE

SOCRATES

Site	LOWER RIGHT SIDED BACK PAIN	Onset	ONGOING
Charactor	SHARP, Constant, Worsening	Radiates	Yes: RADIATE TO LEFT SIDE, BUT MAINLY ON RIGHT SIDE.
Associated Symptoms	Dizziness	Timing	OVER A WEEK
Exacerbating Or Relieving Symptoms	NONE	Severity	7/10

Substances Affecting Condition

Substances	Alcohol

MEDICAL

CLOSE RECORD

Treatment On Scene	Non Emergency

Conveyance

Transport To Hospital	Normal driving	Pre Alert	No

INCIDENT LOG

Time Call Received	00:00	Allocated	23:59	Mobile	00:02
First Resource On Scene		Crew On Scene	00:09	Crew Left Scene	00:46
Crew At Hosp	00:58	Receiving Hospital	ROYAL ALEXANDRA PAISLEY	Clear Time	

Crew ID	Crew Grade	Driver
E9883702	Student Technician Level 4	NO
E9886793	Ambulance Technician	NO

Patient name .....

Patient: 1203893450 M
WEIR
James 12/03/1989

NHS
Greater Glasgow and Clyde

Emergency Care Nursing Documentation

Presenting complaint - and relevant past medical history including allergies

Date and Time		Name/Signature
19/4/20 02:50	NKDA found in close by neighbours.	

Nursing notes - on admission

Date and Time		Name/Signature
02:50	Patient into room wants to be seen	

Triage

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

Communication

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

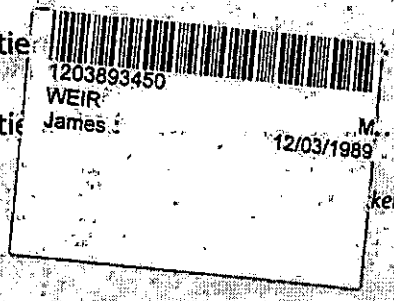
Risk Assessments and Screening Tools

SEPSIS	Y	N	GMAWS	Y	N
FAST	Y	N	Adult Support and Protection	Y	N
Swallow Testing	Y	N	Mental Health Triage Assessment	Y	N
Falls Risk (clinical judgeument)	Y	N	Child Protection Concerns	Y	N

Signature:

Patie

Patie



NHS
Greater Glasgow and Clyde

Care Rounds Checklist

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

Signed _____ Name _____ Designation _____

Signed _____ Name _____ Designation _____

Signed _____ Name _____ Designation _____

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

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

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

Pa
1203893450
WEIR M
James 12/03/1989
Pa
ticker

Hospital: RAH	Points to consider:
Ward: 60	• Use within 8 hrs of admission to care area • Re-assess daily and more frequently if a person's condition changes

NHS
Greater Glasgow and Clyde

PUDRA

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

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

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

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

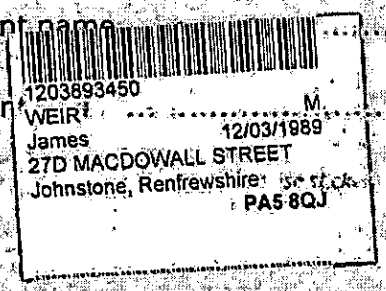
If NO to all statements, continue with patient interventions depending on individual need and reassess daily.

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

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

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

Patient name .....

Patient 

NHS
Greater Glasgow and Clyde

Nursing notes - discharge plannning

Date and Time		Name/Signature

Outcomes and outstanding issues

Date and Time		Name/Signature

Pause for Discharge or Transfer

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

Signature:

Contact with relatives

Signature:

Patien

1203893450
WEIR M
Patien James 12/03/1989
27D MACDOWALL STREET
Johnstone, Renfrewshire
PA5 8QJ

NHS
Greater Glasgow and Clyde

4AT assessment - for delirium and cognitive impairment

		Circle Score
(1) ALERTNESS This includes patients who may be markedly drowsy (eg. dificult 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 (alert, but not agitated, through assessment) Mild sleepiness (<10 secs) after waking, then normal Clearly abnormal	0 0 4
(2) AMT4 Age, date of birth, place (name of the hospital/building), current year.	No mistakes 1 mistake 2 or more mistakes/untestable	0 1 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.	wAchieves 7 months or more correctly Starts but scores <7 months / refuses to start Untestable (cannot start, unwell, drowsy, inattentive	0 1 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 Yes	0 4

4 or more possible delirium + /- cognitive impairment
1-3 possible cognitive impairment
0 delirium or severe cognitive impairment unlikey (but delirium still possibe if (4) information incomplete

TOTAL

Frailty Assessment Tool (Healthcare Improvement Scotland)

Step 1 Would this person benefit from Comprehensive Geriatric Assessment (CGA)?			circle Y or N	
F	**Functional impairment**	(new or worsening) eg difficulty with self care	**Y**	**N**
R	**Resident**	in a care home	**Y**	**N**
A	**Altered mental state**	such as delirium or dementia (**4AT Assessment**)	**Y**	**N**
I	**Immobility/instability**	decline in mobility, difficulty mobilising without help, fall leading to presentation	**Y**	**N**
L	**Living at home with support**	on a daily basis (homecare, one visit or more per day)	**Y**	**N**

If YES to any of the criteria in Step 1 move to Step 2

Step 2 Would this person be better managed by another speciality team at present?	circle Y or N	
Clear need for other specialty input eg exacerbation of known long-term condition such as COPD	**Y**	**N**
Need for HDU/ITU (including non-invasive ventilation)	**Y**	**N**
Suspected new stroke or TIA, consider thrombolysis and care in stroke unit	**Y**	**N**
Head injury with loss of consciousness	**Y**	**N**
Acute abdominal pain/ surgical presentation	**Y**	**N**
Upper GI Bleed	**Y**	**N**
Chest pain with suspected acute coronary syndrome	**Y**	**N**
Trauma with suspected fracture	**Y**	**N**

Are any of the criteria met?
If YES to any criteria in Step 2: Prioritise move to non geriatric service as appropriate. If necessary consider geriatric advice on parent ward.
If YES to any criteria in Step 1 and NO to ALL criteria in STEP 2: Prioritise transfer of care to specialist geriatric assessment service.

Patient

Patient

1203893450
WEIR
James M
27D MACDOWALL STREET
Johnstone, Renfrewshire
12/03/1989
PA5 8QJ

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Nursing notes - ongoing care

Date and Time		Name/Signature

NEWS 2 Key | 1 | 2 | 3

| | | |

NHSGGC NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

Affix Patient ID

12038934S0 12/03/1989
WEIR
James

	Date	Ward	Time
Admitted	19/4/22	AAE	01:30
Transferred			
Transferred			
Transferred			
Transferred			

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

Document all actions and Interventions

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

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

Discontinuation of NEWS

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

Signed.....

Medical:.....

Date:.....

Glasgow Coma Scale

Date:	19/4																								
Time:	11:30																								
Pain filmed by pressing • NT	E Y E S	•	A	Spontaneously	4																				
				To voice	3																				
				To pressure	2																				
				None	1																				
				Non testable	NT																				
Endotracheal tube or tracheostomy = NT	V E R B A L	•	5	Oriented	5																				
			4	Confused	4																				
			3	Words	3																				
			2	Sounds	2																				
			1	None	1																				
			NT	Not testable	NT																				
Always record the best response	M O T O R	•	6	Obeys command	6																				
			5	Localising pressure	5																				
			4	Normal flexion	4																				
			3	Abnormal flexion	3																				
			2	Extension	2																				
			1	None	1																				
			NT	Not testable	NT																				
TOTAL		15																							
Right size:	P U P I L	4																							
Right reaction:		4																							
Left size:		4																							
Left reaction:		4																							
Record right (R) and left (L) separately if there is a difference between the two sides	A R M S	•	R	Normal power																					
				Mild paralysis																					
				Severe weakness																					
				Spastic flexion																					
				Extension																					
				No response																					
Record right (R) and left (L) separately if there is a difference between the two sides	L E G S	•	R	Normal power																					
				Mild weakness																					
				Severe weakness																					
				Spastic flexion																					
				Extension																					
				no response																					

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

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

Affix Patient ID

Pain Score

Ask the patient to rate his/her pain by using numerical scale 0 to 10. Use the chart below to assist the patient. If the patient is unable to communicate, use alternative pain scoring tools.

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

Pain Function Score

Pain		
A	No limitations, activity unrestricted by pain or settles quickly	
B	Mild limitations, mild activity restrictions	
C	Moderate limitations, attempts but reluctant to continue because of pain.	**Seek Advice**
D	Severe limitations, unable to or refuse to perform because of pain.	**Urgent Review Required**

mti • 316654 v5.1 • GGC0264

Patient nam
Patient CHI

1203893450
WEIR M
James 12/03/1989
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Johnstone, Renfrewshire
PA5 8QJ

(A)

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Emergency Care Nursing Documentation

Presenting complaint - and relevant past medical history including allergies

Date and Time		Name/Signature
19/4/22 0445	NKDA	Burke

Nursing notes - on admission

Date and Time		Name/Signature
19/4/22 0445	PATIENT INTO BAY	Burke

Triage

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

Communication

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

Risk Assessments and Screening Tools

SEPSIS	Y	(N)	GMAWS	Y	(N)
FAST	Y	(N)	Adult Support and Protection	Y	N
Swallow Testing	Y	(N)	Mental Health Triage Assessment	Y	N
Falls Risk (clinical judgeument)	Y	(N)	Child Protection Concerns	Y	N

Signature:

Patient nam

Patient CHI

1203893450 M
WEIR 12/03/1989
James
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Johnstone, Renfrewshire
PA5 8QJ

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Care Rounds Checklist

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

Signed _____ Name _____ Designation _____

Signed _____ Name _____ Designation _____

Signed _____ Name _____ Designation _____

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

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

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

Patient name

Patient CHI

1203893450
WEIR M
James 12/03/1989
27D MACDOWALL STREET
Johnstone, Renfrewshire
PA5 8QJ

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Greater Glasgow and Clyde

Nursing notes - discharge plannning

Date and Time		Name/Signature

utcomes and outstanding issues

Date and Time		Name/Signature

Pause for Discharge or Transfer

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

Contact with relatives

Signature:

Patient na

Patient Cl

1203893450
WEIR M
James 12/03/1989
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Johnstone, Renfrewshire
PA5 8QJ

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

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Greater Glasgow and Clyde

PUDRA

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

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

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

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

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

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

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

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

Patient n

Patient Cl

1203893450 M
WEIR 12/03/1989
James
27D MACDOWALL STREET
Johnstone, Renfrewshire
PA5 8QJ

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Greater Glasgow and Clyde

4AT assessment - for delirium and cognitive impairment

		Circle Score
(1) ALERTNESS This includes patients who may be markedly drowsy (eg. dificult 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 (alert, but not agitated, through assessment) Mild sleepiness (<10 secs) after waking, then normal Clearly abnormal	0 0 4
(2) AMT4 Age, date of birth, place (name of the hospital/building), current year.	No mistakes 1 mistake 2 or more mistakes/untestable	0 1 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.	wAchieves 7 months or more correctly Starts but scores <7 months / refuses to start Untestable (cannot start, unwell, drowsy, inattentive	0 1 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 Yes	0 4

4 or more possible delirium +/- cognitive impairment
1-3 possible cognitive impairment
0 delirium or severe cognitive impairment unlikey (but delirium still possibe if (4) information incomplete

TOTAL

Frailty Assessment Tool (Healthcare Improvement Scotland)

Step 1 Would this person benefit from Comprehensive Geriatric Assessment (CGA)? circle Y or N

F	**Functional impairment**	(new or worsening) eg difficulty with self care	**Y**	**N**
R	**Resident**	in a care home	**Y**	**N**
A	**Altered mental state**	such as delirium or dementia **(4AT Assessment)**	**Y**	**N**
I	**Immobility/instability**	decline in mobility, difficulty mobilising without help, fall leading to presentation	**Y**	**N**
L	**Living at home with support**	on a daily basis (homecare, one visit or more per day)	**Y**	**N**

If YES to any of the criteria in Step 1 move to Step 2
Step 2 Would this person be better managed by another speciality team at present? circle Y or N

Clear need for other specialty input eg exacerbation of known long-term condition such as COPD	**Y**	**N**
Need for HDU/ITU (including non-invasive ventilation)	**Y**	**N**
Suspected new stroke or TIA, consider thrombolysis and care in stroke unit	**Y**	**N**
Head injury with loss of consciousness	**Y**	**N**
Acute abdominal pain/ surgical presentation	**Y**	**N**
Upper GI Bleed	**Y**	**N**
Chest pain with suspected acute coronary syndrome	**Y**	**N**
Trauma with suspected fracture	**Y**	**N**

Are any of the criteria met?
If YES to any criteria in Step 2: Prioritise move to non geriatric service as appropriate. If necessary consider geriatric advice on parent ward.
If YES to any criteria in Step 1 and NO to ALL criteria in STEP 2: Prioritise transfer of care to specialist geriatric assessment service.

Patient name

Patient CHI

1203893450
WEIR
James
M
12/03/1989
27D MACDOWALL STREET
Johnstone, Renfrewshire
PA5 8QJ

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Greater Glasgow and Clyde

Nursing notes - ongoing care

Date and Time		Name/Signature

PVS

NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

Royal Alexandra Hospital

CHI: 1203893450

Total Att: 81

12 Mth Att: 0

Title: MR

WEIR **James**

DOB 12/03/1989 Age: 32y Sex: Male

27D MACDOWALL STREET

Johnstone
Renfrewshire
PA5 8QJ
07572 333 730

Next of kin: **WEIR, Deborah**
Relationship: **Sister**
07306306678

GP: **JC Sim**
01505 321733

Attendance Date: **07/03/2022** Arrival Time: **18:40**

Registration Time: **18:40** Date of Incident: **07/03/2022**

Major Incident Desc:

Reason for Attendance: **Acute alcohol withdrawal, bibp**

Affix Label

Nursing Assessment

Alerts: **Yes** Allergies: **Yes** Pain Score:

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

Presenting Complaint:

Observation Date: **07/03/2022 18:41** Nurse name: **Nurse Joanne Rae**

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

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

GCS	
Eyes	
Motor	
Verbal	
Total	

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

Nursing Notes: **"alcohol withdrawl feels suicide "** Right hand injury.

Child Assessment Questionnaire

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

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

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

DO NOT WRITE HERE PLEASE

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

Date	CLINICAL NOTES
	Seen by (Dr) MLawlor Time seen

1203893450 12/03/1989
WEIR
James

Tuesday admitted c CP.
expressed suicidal intent
→ police called.
police arrived CN pt a Tuesday
pt stated 'nothing to alcohol.'
last drink today.
→ set to ATE

pt states suicidal since died today
deceased over alcohol issue
states not getting any help. ? alcohol
has also
no funny drugs

O/E
not intoxicated for alcohol
in my opinion
mild tremor
appropriate. Idiopathic
D/S Wernicke →
will assess Tuesday

Date	CLINICAL NOTES

Discharge Codes (Please CIRCLE)					Discharge date	
1. Admission	2. Discharge	3. Refer to GP	4. Transfer to other (see below)			
5. Died	6. Refer to OP Clinic (see below)		7. Irregular Discharge	8. D.O.A.	Discharge time	

Ward number (if admitted):	Transfer to hospital:	Consultant If admitted):

Follow up	Arranged			Not arranged			To be arranged	
Clinic referred to	A&E	Hand injury	Fracture	Pop Check	Medical	Surgical	ENT	Others (specify):

Discharge Prescription Packs

Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Frequency	Signature	Given By

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

NHS Greater Glasgow and Clyde

1203893450 12/03/1989
WEIR
James

Patient CHI

Part One - Nursing Triage

triage nurse to complete this page

Triage Observations

document physiological measurements

GCS	BM	HR	BP	RR	SaO^2	Temp
		96	144/78	18	97%	37.1

accompanied by

name, relationship, particular concerns

Police

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

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

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

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

Outline of Presentation

tick all the categories which apply

Overdose (will also require medical assessment)	
Self-injury (will also require wound management)	
Other Mental Health Presentation	2

Initial Presentation, Appearance and Behaviour

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

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

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

Triage Risk Assessment

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

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

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

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

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

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

Immediate management

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

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

name/grade JRSC 6

signature J Rae

date and time 7/3/22 1R 45

© NHSGG&C Mental Health and Acute Services Interface Group.

Part Two - Mental Health Assessment

medical staff to complete this page

Patient name _____

CHI _____

outline of current presentation and precipitating factors

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

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

Appearance	Behaviour	Speech
Mood	Thought	Insight

Risk Factors

(this is not an exhaustive list)

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

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

Risk Assessment

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

High / Moderate / Low

Discharge Advice and Plan for Further Assessment

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

summary	follow up and advice given

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

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

name/grade _____

signature _____

date and time _____

© NHSGG&C Mental Health and Acute Services Interface Group.

NEWS 2 Key | 1 | 2 | 3 |

| | | |

NHSGGC NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

Affix Patient ID

1203893450 12053989
WEIR
James

	Date	Ward	Time
Admitted			
Transferred			
Transferred			
Transferred			
Transferred			

Sp02 Scale 1 **Target >96%**
Signature:
Print Name:
Dr/ANP initials ONLY:
Date:

Sp02 Scale 2 **Target 88-92%**
Signature:
Print Name:
Dr/ANP initials ONLY:
Date:

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

Document all actions and interventions

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

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

Discontinuation of NEWS

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

Signed.....

Medical: .....

Date: .....

Glasgow Coma Scale

Date:																								
Time:																								
Eyes closed by swelling = NT	E																							
	V																							
	E																							
	S																							
Endotracheal tube or tracheostomy = NT	V																							
	E																							
	R																							
	B																							
	A																							
	L																							
Always record the best response	M																							
	O																							
	T																							
	O																							
	R																							
TOTAL																								
Right size:	P																							
Right reaction:	U																							
Left size:	P																							
Left reaction:	L																							
Record right (R) and left (L) separately if there is a difference between the two sides	A																							
	R																							
	M																							
	S																							
Record right (R) and left (L) separately if there is a difference between the two sides	L																							
	E																							
	G																							
	S																							

Spontaneously 4
To sound 3
To pressure 2
None 1
Non-testable NT

Oriented 5
Confused 4
Words 3
Sounds 2
None 1
Non-testable NT

Obeys command 6
Localising pain 5
Normal flexion 4
Abnormal flexion 3
Extension 2
None 1
Non-testable NT

Normal power
Mild weakness
Severe weakness
Spastic flexion
Extension
No response
Non-testable NT

Normal power
Mild weakness
Severe weakness
Spastic flexion
Extension
No response

Pupil Reaction and Size

S = sluggish
+ = reaction
- = no reaction
C = eyes

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

Affix Patient ID

Pain Score

Ask the patient to rate his/her pain by using numerical scale 0 to 10. Use the chart below to assist the patient. If the patient is unable to communicate, use alternative pain scoring tools.

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

Pain Function Score

A	No limitations, activity unrestricted by pain or settles quickly
B	Mild limitations, mild activity restrictions
C	Moderate limitations, attempts but reluctant to continue because of pain. **Seek Advice**
D	Severe limitations, unable to or refuse to perform because of pain. **Urgent Review Required**

mi • 316654 v5.1 • GGC0264

NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

Affix Label

CHI: 1203893450

Royal Alexandra Hospital

Total Att: 80

12 Mth Att: 1

Title: MR

WEIR **James**

DOB **12/03/1989** Age: **31y** Sex: **Male**

27D MACDOWALL STREET

Johnstone
Renfrewshire
PA5 8QJ
07572 333 730

Next of kin: **WEIR, Deborah**
Relationship: **Sister**
07474837113

GP: **JC Sim**
01505 321733

Attendance Date: **11/06/2020** Arrival Time: **00:16**

Registration Time: **00:16** Date of Incident: **11/06/2020**

Major Incident Desc:

Reason for Attendance: **mhi**

Affix Label

Nursing Assessment

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

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

Presenting Complaint:

Observation Date: **11/06/2020 00:26** Nurse name: **Nurse Michelle McMillan**

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

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

GCS	
Eyes	
Motor	
Verbal	
Total	

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

Nursing Notes: **return to ED having been in an inpatient in AMU ? alcohol withdrawal diazepam given earlier no evidence of withdrawla in triage**

Child Assessment Questionnaire

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

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

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

DO NOT WRITE HERE PLEASE

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

Date	CLINICAL NOTES
	Seen by (Dr) Dr T. Cooper. Time seen 00:50
11/6/20	31 yr ♂ – Admitted earlier to AMU → Alcohol withdrawal ?GI bleed. – Disruptive on the ward – abusive to another patient abusive to staff Asked by Bed manager to leave. Given 20mg diazepam with day shift. Well with night shift, (N) Obs No vomiting or evidence of GI bleeding during admission. – Represented to ED after leaving. Not complaining of any symptoms but wanting to tell me that staff on AMU were abusive to him. Now wishes care but remains agitated and verbally abusive. NEWS 2 – T35.4 other markers (N). HR102. Given abusive behaviour on AMU – seems medically ~~and~~ error of well and has ~~of~~ capacity – Asked to leave due to behaviour. Advised that we will not offer further treatment or assessment this evening, excluding life threatening medical emergency. Agitated, upset as has left place. As myself and the HCSW left room – he slammed the door hitting into HCSW, who

12/03/1989
12038934450
WEIR
James

Date	CLINICAL NOTES
11/6/20	turned round and nen was grabbed by the uniform by the patient. Escalated with senior charge nurse coming to door - door closed to keep staff safe from patient who continued to be violent. 999 called.
01-20.	Patient pulled door open and left ~~of~~ his own ~~control~~ error decision.. Police attended - informed due to verbal and physical aggression to staff we will not provide further care to Mr weir tonight, with the exception of life threatening medical emergency.

Discharge Codes (Please CIRCLE)					Discharge date	11/6/20
1. Admission	2. Discharge	3. Refer to GP	4. ~~Transfer to other~~ (see below)			
5. Died	6. Refer to OP Clinic (see below)		7. Irregular Discharge	8. D.O.A.	Discharge time	

Ward number (if admitted):	Transfer to hospital:	Consultant If admitted):

Follow up	Arranged		Not arranged			To be arranged	
Clinic referred to	A&E	Hand injury	Fracture	Pop Check	Medical	Surgical	ENT	Others (specify):

Discharge Prescription Packs

Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Frequency	Signature	Given By

NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

Name
Address



CHI No.
DoB

	Date	Ward
Admitted	11/6/20	ED
Transferred		
Transferred		

Physiological Parameter	NEWS – NHS Early Warning Score						
	3	2	1	0	1	2	3
Respiration Rate	≤8		9-11	12-20		21-24	≥25
Oxygen Saturations	≤91	92-93	94-95	≥96			
Any Supplemental Oxygen		Yes		No			
Temperature	≤35.0°		35.1-36.0°	36.1-38.0°	38.1-39°	≥39.1°	
Pulse	≤40		41-50	51-90	91-110	111-130	≥131
Systolic BP	≤90	91-100	101-110	111-219			≥220
Conscious Level				A			V, P or U

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

See NEWS Actions Reference Tool for local escalation policy

NEWS Score	Frequency of Monitoring	Clinical Response
0	Minimum 12 hourly	• Continue routine NEWS monitoring with every set of observations.
Aggregate 1- 4	Minimum 4 hourly	• Inform trained nurse. • Trained Nurse assessment: - Assess the patient - Review frequency of monitoring required - Assess need for escalation of clinical care and direct as appropriate.
Aggregate 5 or more or 3 in one parameter	Increased frequency to a minimum of 1 hourly	• Trained Nurse assessment. • Inform medical team caring for the patient. • Urgent assessment by a medical / surgical / nursing team with core competencies to assess acutely ill patients. • Consider level of monitoring required in relation to clinical care.
Aggregate 7 or more	Continuous monitoring of vital signs	• Trained Nurse to assess immediately. • Inform medical team caring for the patient – this should be at least senior medical staff level. • Emergency assessment by a clinical team with core competencies in the assessment of critically ill patients. This team will have critical care competencies and a practitioner/s with advanced airway skills and resuscitation skills. • Consider referral to high dependency or ITU.

| | | |

KEY

2 | 3

DATE

TIME

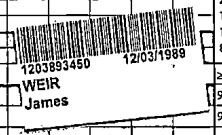
Resp. Rate: 35 30 25 20 16 12 8

SpO2: ≥ 96 | 94-95 | 92-93 | ≤ 91 | %

Temp.: 39° 38.5° 38° 37.5° 37° 36.5° 36° 35.5° 35°

Pulse: 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50

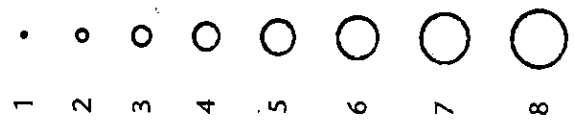
Blood Pressure: 170 160 150 140 130 120 110 100 90 80 70 60 50



Alert	Alert
Verbal	Verbal
Pain	Pain
Unresp	Unresp
NEWS SCORE	NEWS SCORE
BM	BM
Pain	Pain
Nausea	Nausea
Urine output	U/O
Obs due	Obs due
Initials	Initials

Glasgow Coma Scale

Pupil size (mm)



Neurological Observations

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

Pain Score

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

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

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

Management Plan and Patient Exclusions

Date and Time	Notes	Signed

You can find the latest version of this guidance on our website at www.gmc-uk.org/guidance

Published 25 March 2013 | Comes into effect 22 April 2013

General Medical Council

Ending your professional relationship with a patient

1203893450 12/03/1989
WEIR
James

1 In *Good medical practice*[1] we say:

> 62 You should end a professional relationship with a patient only when the breakdown of trust between you and the patient means you cannot provide good clinical care to the patient.

2 In this guidance, we explain how doctors can put this principle into practice. Serious or persistent failure to follow this guidance will put your registration at risk.

Things to consider

3 In rare circumstances, the trust between you and a patient may break down, for example, if the patient has:

- been violent, threatening or abusive to you or a colleague[2]
- stolen from you or the premises[3]
- persistently acted inconsiderately or unreasonably
- made a sexual advance[4] to you.

4 You should not end a professional relationship with a patient solely because of a complaint the patient has made about you or your team, or because of the resource implications of the patient's care or treatment.

Before you end the relationship

5 Before you end a professional relationship with a patient you should:

a warn the patient that you are considering ending the relationship

b do what you can to restore the professional relationship

c explore alternatives to ending the professional relationship

d discuss the situation with an experienced colleague or your employer or contracting body

and you must be satisfied that your reason for wanting to end the relationship is fair and does not discriminate against the patient (see paragraph 59 of *Good medical practice*).

1203893450 12/03/1989
WEIR
James

When you've made a decision to end the relationship

6 If you decide to end your professional relationship with a patient you must:

- **a** make sure the patient is told of your decision to end the professional relationship, and your reasons for doing so; where practical, the patient should be told in writing
- **b** follow relevant guidance[5] and regulations
- **c** record your decision to end the professional relationship – information recorded in the patient's records must be factual and objective, and should not include anything that could unfairly prejudice the patient's future treatment
- **d** make sure arrangements are made promptly for the continuing care of the patient, and you must pass on the patient's records without delay[6]
- **e** be prepared to justify your decision.

Closing or relocating your practice

7 If you are closing or relocating your practice, you should:

- **a** give advance notice
- **b** make sure that arrangements are made for the continuing care of all your current patients, including the transfer (or appropriate management) of all patient records.

Further sources of information and advice

England

Department of Health
Health service circular 2000/001 *Tackling violence towards GPs and their staff*
www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Healthservicecirculars/DH_4003798

British Medical Association – General Practitioners Committee (GPC)
Removal of patients from GP lists
www.bma.org.uk/-/media/Files/PDFs/Practical%20advice%20at%20work/Doctors%20as%20managers/gpremovepats0405.pdf

Medical Protection Society
Removing patients from the practice list (see also factsheets for all four UK countries)
www.medicalprotection.org/uk/your-practice-december-2012/removing-patients-from-the-practice-list

Medical Defence Union
www.the-mdu.com

Parliamentary and Health Service Ombudsman
Listening and Learning: the Ombudsman's review of complaint handling by the NHS in England 2011–12
https://www.ombudsman.org.uk/publications/listening-and-learning-ombudsmans-review-complaint-handling-nhs-england-2011-12

Case studies on removal from lists
https://www.ombudsman.org.uk/about-us/how-our-casework-makes-difference/case-summaries/1023

Case studies from the Ombudsman's review of complaint handling in England
https://www.ombudsman.org.uk/about-us/how-our-casework-makes-difference/case-summaries

Medical and Dental Defence Union of Scotland (MDDUS)
Risk alert – think before removing patients (30 November 2011)
www.mddus.com/risk-management/risk-alerts/2011/november/think-before-removing-patients

Northen Ireland

The Health and Personal Social Services (General Medical Services Contracts) Regulations (Northern Ireland) 2004 – part two covers removal from GP lists in a range of scenarios
www.dhsspsni.gov.uk/no140_gms_contract_regs_bm3.pdf

Scotland

Medical and Dental Defence Union of Scotland (MDDUS)
Risk alert – think before removing patients (30 November 2011)
www.mddus.com/risk-management/risk-alerts/2011/november/think-before-removing-patients

Scottish Online Appraisal Resource (SOAR) for GPs in Scotland
Section on relationships with patients including removal of patients from GP lists
www.scottishappraisal.scot.nhs.uk/toolkit/relationships-with-patients-(gp-scot-1c).aspx

Endnotes

1 General Medical Council (2013) *Good medical practice* London, GMC.

2 See Health Service Circular 2001/18 *Withholding treatment from violent and abusive patients in NHS Trusts.*

3 If you decide to inform the police about a patient you must follow our guidance on confidentiality. General Medical Council (2017) *Confidentiality: good practice in handling patient information* London, GMC.

4 You must also follow our guidance on maintaining a professional boundary between you and your patient (see paragraph 7). General Medical Council (2013) *Maintaining a professional boundary between you and your patient* London, GMC.

5 See *Listening and Learning: the Ombudsman's review of complaint handling by the NHS in England* 2010-11.

6 General Medical Council (2013) *Good medical practice* London, GMC, paragraph 44.

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Code: GMC/EPRWP/0317

NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

Affix Label

CHI: 1203893450

Royal Alexandra Hospital

Total Att: 78

12 Mth Att: 2

Title: **MR**

WEIR **James**

DOB: **12/03/1989** Age: **29y** Sex: **Male**

27D MACDOWALL STREET

Johnstone
Renfrewshire
PA5 8QJ
07377865873

Next of kin: **WEIR, Deborah**
Relationship: **Sister**
07474837113

GP: **JC Sim**
01505 321733

Attendance Date: **04/03/2019** Arrival Time: **23:08**

Registration Time: **23:08** Date of Incident: **04/03/2019**

Major Incident Desc:

Reason for Attendance: **exam**

Affix Label

Nursing Assessment

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

Triage Category: **5** Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: **04/03/2019 23:57** Nurse name: **Nurse Michelle McCafferty**

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

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

GCS	
Eyes	
Motor	
Verbal	
Total	

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

Nursing Notes: **called to triage at 2340, no reply**

Child Assessment Questionnaire

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

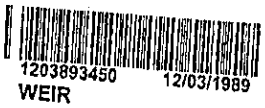
Discuss with Senior Medical Staff / Nurse on duty any factors identified

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

DO NOT WRITE HERE PLEASE

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

Date	CLINICAL NOTES
	Seen by (Dr) Time seen



Date	CLINICAL NOTES

Discharge Codes (Please CIRCLE)					Discharge date	
1. Admission	2. Discharge	3. Refer to GP	4. Transfer to other (see below)			
5. Died	6. Refer to OP Clinic (see below)		7. Irregular Discharge	8. D.O.A.	Discharge time	

Ward number (if admitted):	Transfer to hospital:	Consultant If admitted):

Follow up	Arranged	Not arranged	To be arranged

Clinic referred to	A&E	Hand injury	Fracture	Pop Check	Medical	Surgical	ENT	Others (specify):

Discharge Prescription Packs

Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Frequency	Signature	Given By

E Boice 3

NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

Royal Alexandra Hospital

CHI: 1203893450

Total Att: 77

12 Mth Att: 2

Title: MR

WEIR **James**

DOB: **12/03/1989** Age: **29y** Sex: **Male**

27D MACDOWALL STREET

Johnstone
Renfrewshire
PA5 8QJ
07377865873

Next of kin: **WEIR, Deborah**
Relationship: **Sister**
07474837113

GP: **JC Sim**
01505 321733

Attendance Date: **28/08/2018** Arrival Time: **23:20**

Registration Time: **23:20** Date of Incident: **28/08/2018**

Major Incident Desc:

Reason for Attendance: **suicidal**

Nursing Assessment

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

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

Presenting Complaint:

Observation Date: **28/08/2018 23:58** Nurse name: **Nurse Michelle Mccord**

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

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

Visual Acuity	
Left	
Right	
Corrected?	

GCS	
Eyes	
Motor	
Verbal	
Total	

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

Nursing Notes: **"agitated and aggressive tonight stated he is suicidal, police called CPNs in community did not want to see James tonight. "**

Child Assessment Questionnaire

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

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

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

DO NOT WRITE HERE PLEASE

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

29/08/2018 **CLINICAL NOTES**

Seen by (Dr) EMEKA Time seen 01:40

Pt accompanied by 2 Police Officers; who exited room to allow pt and I to converse in private.

James: GCS -15/15, scent of alcohol perceptible on his breath; admitted he'd drunk 1½ bottle of "Buckfast" today. Couldn't tell me how he came to be in custody of police. Began to speak about his ~~be~~ having been a victim of sexual abuse and how the NHS has failed him; how he needs help and no one seems to care, and he is all alone.

Then he became agitated, and verbally aggressive, saying we were wasting time talking and he needed help.

I walked out of the room as I no longer felt safe around pt. Police officers came back in. Pt tried to storm out of room and they restrained him.

I spoke with Mr Reynolds who answered the OOH CPN telephone; took above details plus pt's name and DOB and said he'd kindly arrange for a CPN to phone me back.

29/08/18 02:20 Received call from CPN Sharon Swan Ubuelin GRST2 who had spoken to James and police officers who had initially been to him in his home & from their earlier conversation, it was evident that James had had 'disturbing thoughts' which had left him quite ~~agitated~~ more agitated, however, he

Date	29/8/18	CLINICAL NOTES

Emerg GPST2 Notes contd.

had not expressed any clear plan or intent to harm himself or anyone else. As such the CPN had found no reason to come out to assess him at that time, and even presently, the situation was much the same.

James at that time, and likewise presently was vexed by this and refused to engage further w the CPN. They had however gone on to provide him w a phone # (0845 650 1730) to phone during working hours today, in order to arrange follow up psych. mental health assessment. Shaken reiterated this advice which I passed on to James in presence of the 2 police officers present. Again he became agitated and upset.

In the light of above, I see no reason to admit or section Mr James Weir at this time and advised him to contact the CPNs as he was advised.

Emerg / GPST2
d/w Dr G-Manson

Discharge Codes (Please CIRCLE)					Discharge date	29/8/18
1. Admission	2. Discharge	3. Refer to GP	4. Transfer to other (see below)		Discharge time	0250
5. Died	6. Refer to OP Clinic (see below)		7. Irregular Discharge	8. D.O.A.		

Ward number (if admitted):	Transfer to hospital:	Consultant If admitted):

Follow up	Arranged			Not arranged			To be arranged	by patient to CPNs.
Clinic referred to	A&E	Hand injury	Fracture	Pop Check	Medical	Surgical	ENT	Others (specify):

Discharge Prescription Packs

Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Frequency	Signature	Given By

Emergency Department
Mental Health Triage and Risk Assessment

NHS
1203893450
1 WEIR
9 James
sgow
Me
12/03/198

Emergency Department Triage
This side to be completed by triage nurse

Patient Nr
DoB

Triage Observations
Document physiological measurements

GCS	BM	HR	BP	RR	SaO_2	Temp

Accompanied by
Name, relationship, particular concerns

Police.. Greyhoodie, Black trousers Jeans Short hair

Or describe the patient's physical appearance/clothing if attending alone as they may leave before assessment

Is the patient a young person in foster care or in a residential care placement? Yes/No

Is the patient a carer for a child or for a dependent adult? Yes/No

Is there a child protection concern or concern for an adult at risk? Yes/No

Outline of Presentation
Tick all those categories which apply and provide a brief summary

Overdose – will require medical assessment		Social.
Self-Injury - will require wound management		
Other Mental Health Presentation	X	

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

Is the patient violent, aggressive or threatening?	Yes		No
Is the patient obviously distressed, markedly anxious or highly aroused?		Yes	No
Is the patient quiet and withdrawn?		Yes	No
Do you think the patient is behaving inappropriately to their situation?		Yes	No
Do you think the patient presents an immediate risk to you, to others, or to themselves?	Yes		No
Do you think the patient is likely to abscond prior to assessment?	Yes		No
Do you think the patient's presentation suggests either delusions or hallucinations?*	Yes		No
Do you think the patient's presentation suggests they feel their actions are being controlled?	Yes		No
Are you aware of a history of mental health problems or psychiatric illness?		Yes	No
Are you aware of a history of violence or self harm?		Yes	No
Is the patient currently expressing suicidal thoughts	Yes		No

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

Triage Risk Assessment
Indicate an initial category of risk by circling one and selecting one or more risks

High/Moderate/Low Risk

of self-harm/violence/absconding in department

Triage Category	
	high risk – supervised *and* in the department moderate risk – supervised *or* in the department low risk – can be asked to wait if necessary

Any responses in the first column
High Risk

Other patients can be categorized as
Moderate Risk

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

Immediate Management
Print toxbase information, and in paracetamol overdose, document 4 hour time for sample

Patient location, supervised by...	Police		
Blood sample time?		Toxbase Information Printed?	

Print Name MMcCall

Signature

Date 28/8/18 Time 2355

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Emergency Department Mental Health Assessment

This data to be completed by medical staff

Outline of current presentation and precipitating factors

Previous mental health problems, self harm, addictions, medication etc

Other relevant information; relationships, finances, employment, housing, physical health, childcare etc

Appearance	Behaviour	Speech
Mood	Thought	Insight

Risk Assessment

Based on clinical assessment indicate a category of risk for a further episode of self-harm in the short term (~48 hrs) considering any protective as well as precipitating factors

High/Moderate/Low

Summary and Plan for Further Assessment

Referral to liaison psychiatry, duty doctor, CPN, service, CMHT, GP, addiction services, SW etc

Summary

Service Referred to	Time of Referral

Discharge

Indicate the follow up plan, advice given and identities of others informed of the decision

Follow up and advice	Carer informed

Name and Designation of Consultant or Middle-Grade Involved in Reviewing Patient	

Risk Factors (yes/no/unknown)

male gender	y	n	u
age >18 and <65	y	n	u
depression	y	n	u
alcohol or drug use	y	n	u
separated, widowed, divorced	y	n	u
suicide plan/concealment	y	n	u
evidence of psychosis	y	n	u
ongoing suicial intent	y	n	u
lack of social support	y	n	u
chronic physical illness/pain	y	n	u
family history of suicide	y	n	u
family concerned about risk	y	n	u
disengaged/poor compliance	y	n	u
unemployed or retired	y	n	u
access to lethal means of harm	y	n	u
previous violent methods	y	n	u
history of self harm/overdose	y	n	u
previous psychiatric treatment	y	n	u
current psychiatric treatment	y	n	u
current use of benzodiazepines	y	n	u

If young people in foster or residential care are assessed, their social work team should be informed, (via standby SW if out-of-hours), ***and*** correspondence given to carers present.

Print Name _____

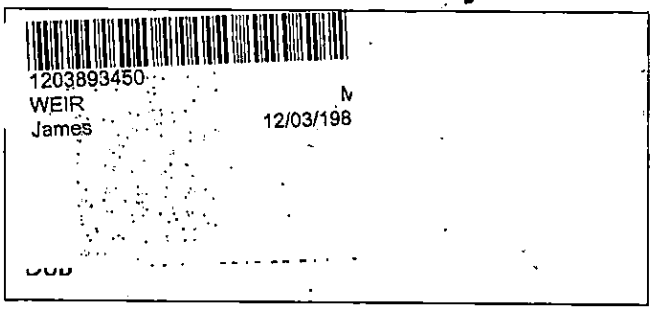
Signature _____

Date & Time _____

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version 2.0 – February 2013

NEWS – National Early Warning Score

NHS
Greater Glasgow and Clyde



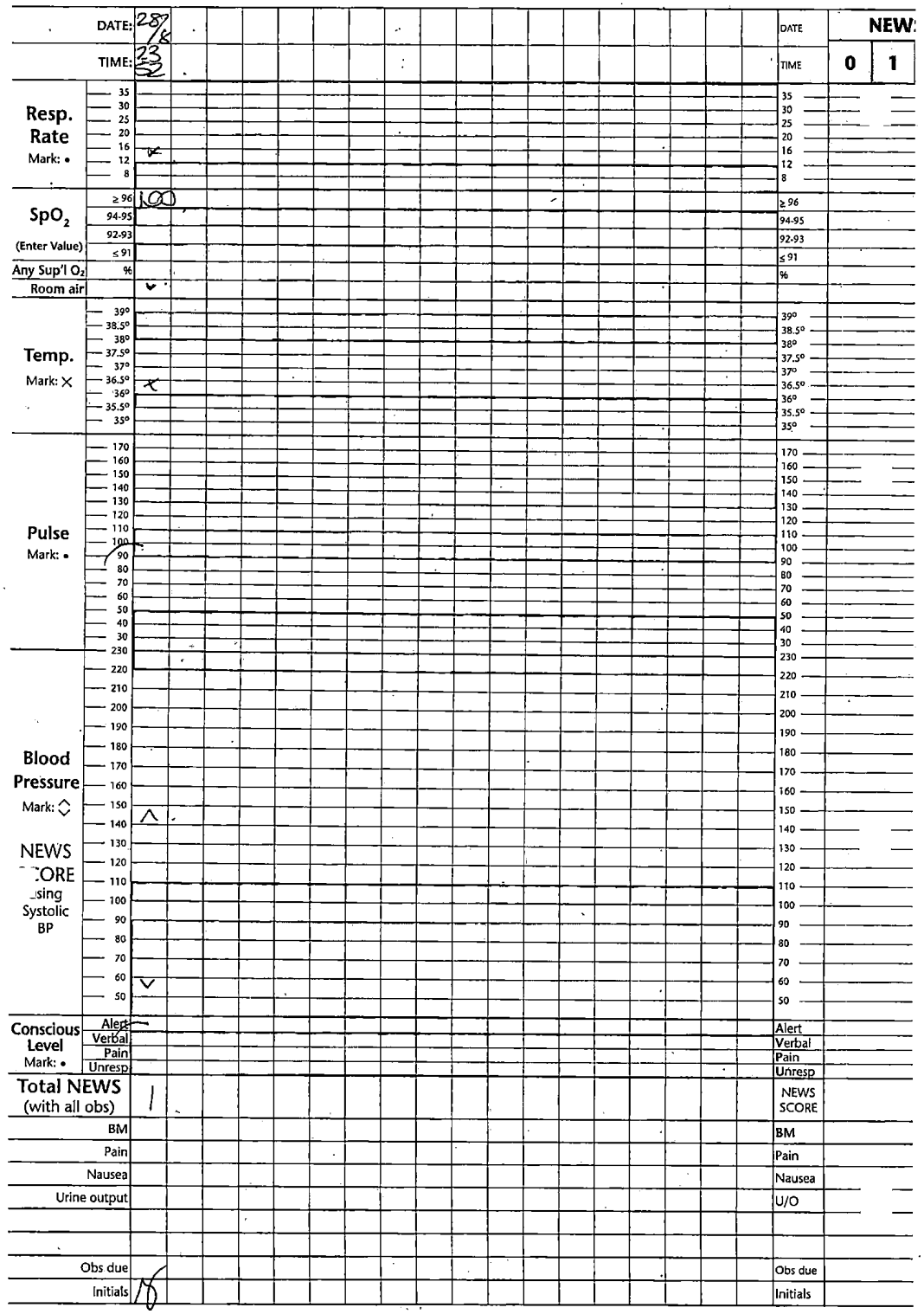
	Date	Ward
Admitted		
Transferred		
Transferred		

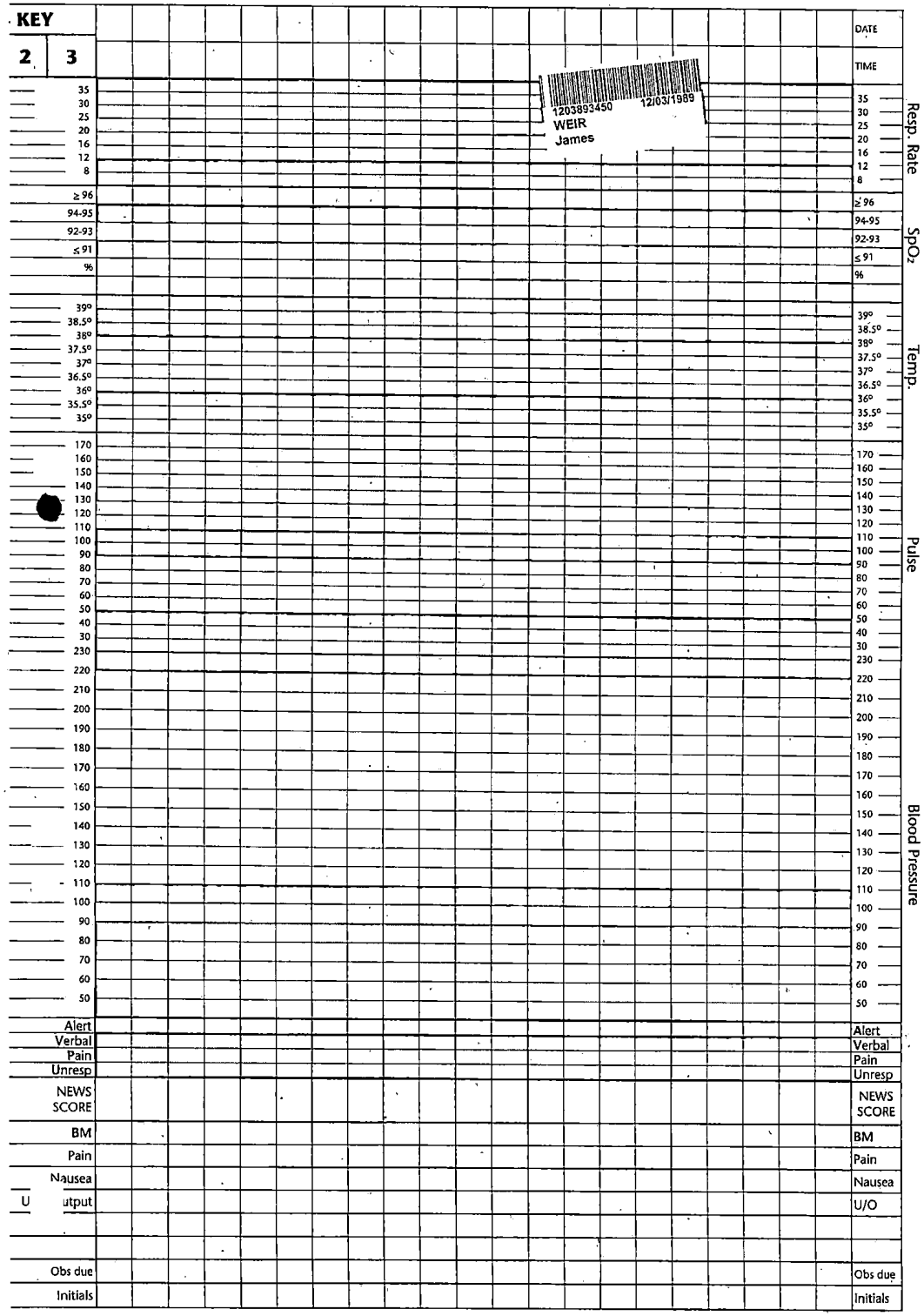
Physiological Parameter	NEWS – NHS Early Warning Score						
	3	2	1	0	1	2	3
Respiration Rate	≤8		9-11	12-20		21-24	≥25
Oxygen Saturations	≤91	92-93	94-95	≥96			
Any Supplemental Oxygen		Yes		No			
Temperature	≤35.0°		35.1-36.0°	36.1-38.0°	38.1-39°	≥39.1°	
Pulse	≤40		41-50	51-90	91-110	111-130	≥131
Systolic BP	≤90	91-100	101-110	111-219			≥220
Conscious Level				A			V, P or U

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

See NEWS Actions Reference Tool for local escalation policy

NEWS Score	Frequency of Monitoring	Clinical Response
0	Minimum 12 hourly	• Continue routine NEWS monitoring with every set of observations.
Aggregate 1- 4	Minimum 4 hourly	• Inform trained nurse. • Trained Nurse assessment: - Assess the patient - Review frequency of monitoring required - Assess need for escalation of clinical care and direct as appropriate.
Aggregate 5 or more or 3 in one parameter	Increased frequency to a minimum of 1 hourly	• Trained Nurse assessment. • Inform medical team caring for the patient. • Urgent assessment by a medical / surgical / nursing team with core competencies to assess acutely ill patients. • Consider level of monitoring required in relation to clinical care.
Aggregate 7 or more	Continuous monitoring of vital signs	• Trained Nurse to assess immediately. • Inform medical team caring for the patient – this should be at least senior medical staff level. • Emergency assessment by a clinical team with core competencies in the assessment of critically ill patients. This team will have critical care competencies and a practitioner/s with advanced airway skills and resuscitation skills. • Consider referral to high dependency or ITU.


DATE: 28/
TIME: 23
Resp. Rate
Mark: •
35 30 25 20 16 12 8
SpO2
(Enter Value)
≥ 96 94-95 92-93 ≤ 91
Any Sup'l O2
%
Room air
Temp.
Mark: ×
39° 38.5° 38° 37.5° 37° 36.5° 36° 35.5° 35°
Pulse
Mark: •
170 160 150 140 130 120 110 100 90 80 70 60 50 40 30
Blood Pressure
Mark: ◇
230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50
NEWS SCORE
using Systolic BP
Conscious Level
Mark: •
Alert
Verbal
Pain
Unresp
Total NEWS (with all obs)
BM
Pain
Nausea
Urine output
Obs due
Initials
DATE
TIME
NEWS
0 1
NEWS SCORE
BM
Pain
Nausea
U/O
Obs due
Initials


KEY
2
3
12038934450 12/03/1989
WEIR
James
DATE
TIME
Resp. Rate
SpO2
Temp.
Pulse
Blood Pressure
35
30
25
20
16
12
8
≥ 96
94-95
92-93
≤ 91
%
39°
38.5°
38°
37.5°
37°
36.5°
36°
35.5°
35°
170
160
150
140
130
120
110
100
90
80
70
60
50
40
30
230
220
210
200
190
180
170
160
150
140
130
120
110
100
90
80
70
60
50
Alert
Verbal
Pain
Unresp
NEWS SCORE
BM
Pain
Nausea
U utput
U/O
Obs due
Initials

Glasgow Coma Scale

Pupil size (mm)

1 • 2 ● 3 4 5 6 7 8

Neurological Observations

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

Pain Score

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

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

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

Management Plan and Patient Exclusions

Date and Time	Notes	Signed

Emergency Department Nursing Documentation

Presenting Complaint: Suicidal

Date and Time: 29/8/18 0130

NHS Greater Glasgow and Clyde

Pat 1203893450 M
WEIR 12/03/1989
James
27D MACDOWALL STREET
Johnstone, Renfrewshire PA5 8QJ

Named Nurse(s): E Cilmer

Patient preparation (Please tick when completed)	Initials: EC	Communication (Please tick when completed)	Initials: EC
Prepare patient for examination and provide blankets if required NA.	☒	Communication Aids (spectacles / hearing aid)	☐
Clothing bagged, labelled and stored under trolley NA	☒	Relatives present, who? Police	☐
Name-band (if required) NKDA	☑	Relatives / NOK informed	☐
		Interpreter required	☐
		Telephone interpretation required	☐

Observations and Investigations (Please tick when completed)		Initials:
Vital Signs recorded on NEWS chart and NEWS score recorded. Record Pain, blood sugar and neuro obs on NEWS chart if appropriate.	☑	IV cannula (if required) ☐
Peak Flow 1. 2. 3.	☐	Blood samples taken ☐
12 Lead ECG	☐	Urinalysis and Specimen if indicated ☐
Cardiac Monitoring	☐	*Results:*
X-rays performed	☐	HCG specimen if indicated ☐
		+ve ☐ -ve ☐ Strip Lot no:
Other: please add	☐	Weight: ☐

Screening Tools (Please circle or tick as appropriate)		Initials: EC
SEPSIS *risk?* SIRS Criteria 2 or more and suspicion of infection Y/N Sepsis 6 protocol initialise and departmental documentation started Y/N		**Preliminary Pressure Ulcer Risk Assessment** Y/N The patient can reposition themselves whilst in the department?
AMT 4 (if >65 years) SCORE	/4	There is **no** reported skin damaged other than presenting trauma? Y/N
At risk of falls? (clinical judgement) (consider alcohol, mobility, age, illness, cognitive impairment etc). *If at risk complete risk assessment*	Y/N	The person is fully continent? Y/N *If NO to any of the above initiate Waterlow risk assessment (within 4 hrs)*
Mental Health Triage Assessment	Y/N	**Waterlow Score** *If >10 commence Active Care* ☐
Child Protection considered (in line with policy)	Y/N	**Active Care** (clinical judgement) (include all trolley patients at risk of pressure ulcers and all trolley patients in department for >4hrs) ☐
FAST	Y/N	*Record on Active Care Chart*
GMAWS	Y/N	Pressure damage identified on arrival in ED is documented in clinical notes ☐
Has Swallow test been carried out?	Y/N	Grade 3 or 4 Pressure Ulcers are reported on DATIX ☐

Pause for Transfer (Please tick when completed)		Tick when completed	N/A	Notes
	Relatives informed	☐	☐	Information on discussion with relatives
	Cannula	☐	☐	
	Name band	☐	☐	
	AMT4	☐	☐	
	NEWS chart NEWS >7 - Name and Page number of senior doctor caring for patient	☐	Always	
Prescriptions signed	Infusions	☐	☐	
	Drugs	☐	☐	
	Allergies are recorded (e.g. on Kardex)	☐	☐	
	Fluids	☐	☐	
	Two hour plan in place e.g. Fluids, Antibiotics and emergency drugs written up on Kardex	☐	☐	
	GMAWS	☐	☐	
	Belongings (including patient's medications)	☐	Always	Please note here if any other tasks required prior to transfer
	Bed requested, accepted and ward informed	☐	Always	
	Notes: medical notes, GP letter, PRF	☐	Always	
Investigations	CXR reviewed	☐		
	ECG reviewed	☐	☐	Print name
	Bloods sent	☐	☐	
	Bloods reviewed	☐	☐	
	Patient on O_2: cylinder checked	☐	☐	
	Patients requiring analgesia: sufficient	☐	☐	

Patient

1203893450
WEIR M
James 12/03/1989
27D MACDOWALL STREET
Johnstone, Renfrewshire
PA5 8QJ

Pause for Discharge (Please tick when completed)	Tick when completed	N/A	Notes
Advice leaflets given	☐	☐	Information on discussion with relatives
Belongings (including patient's medications)	☐	Always	
New medications explained	☐	☐	
Cannula removed	☐	☐	
Relatives aware of discharge	☐	☐	Please note here if any other tasks required prior to discharge
Social/ Support Services required and contacted	☐	☐	
SAS transport required and ref no	☐	☐	Print name
Other means of transport arranged by nurse	☐	☐	

Nursing Notes and Care Plan

Date and Time		Print Name and Signature
0131	Patient into room awaiting ED review	E Collins
0140	Dr space with mental health team, not prepared to attend the dept, will provide support in community tomorrow as discussed earlier.	

Patient Addressograph Label

1203893450 12/03/1989
WEIR
James

Nursing Notes and Care Plan

Date and Time		Print Name and Signature

Emergency Department - Active Care

1203893450
WEIR M
9 James 12/03/1989

abel

I have evaluated and deemed that the frequency of care delivery over the next work shift, based on the patient's most critical need should be every:

(Please circle) ½ hour 1hour 2 hours

Signed ..... Name .....

USE FOLLOWING CODE:
O = Off the ward V = Variant S = Sleeping I = Independent NT = No Thanks

			Time							
	1.	**PAIN:** Assess and address If in pain inform registered nurse Y/ N or N/A	N							
S	2.	**SKIN INSPECTION** Pressure areas checked: Y / N / I (independent)	I							
		Redness (R) / Discolouration (D) / Pressure Ulcer (PU) / Intact (INT)	/							
K	3.	**KEEP MOVING:** Have you moved or walked Y / N / I (independent)	I							
		Bed Right side (30° tilt) – R Left Side (30° tilt) – L Back– B	/							
		Chair Assist to walk, stand or tilt (W /ST/ T)	/							
I	4.	**ELIMINATION:** Do you need the toilet? I = Independent A = Assistance given IC = patient incontinent of urine/faeces	I							
N	5.	**FOOD, FLUIDS AND NUTRITION:** Is the patient nil by mouth? Y / N (consider mouth care)	Y							
		Encourage the patient to drink? **(If appropriate)** Y / N / N/A	/							
		Food, snack or supplement taken? **(If appropriate)** Y / N / N/A	/							
	6.	**ENVIRONMENT:** Is the patient able to call for assistance? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position? Y / N	Y							
	7.	**INFORMATION: Ask:** Is there anything else I can help you with? Inform patient of the time of return. Y / N	N							
	8.	**ESCALATION:** Escalate any issues to the Registered Nurse? Y / N/A	N							
		Nurse Initials								

USE FOLLOWING CODE	Specialist Pressure Redistributing equipment	Variations			
V = Variant I = Independent NT = No thanks	☐ Repose Mattress ☐ Moving and handling aids ☐ Other:	Time	No.	Variation	Signed

aterlow Pressure Area Risk Assessment

Build/Weight		Skin Type/Visual Risk Areas		Sex/Age		Special Risks - Tissue Malnutrition	
Average (BMI 20-24.9)	0	Healthy	0	Male	1	Multiple organ failure/ Terminal cachexia	8
Above Average (BMI 25-29.9)	1	Tissue Paper (thin/fragile)	1	Female	2		
Obese (BMI > 30)	2	Dry (appears flaky)	1	14-49	1	Single organ failure	5
Below Average (BMI < 20)	3	Oedematous (puffy)	1	50-64	2	Peripheral Vascular Disease	5
Continence		Clammy /pyrexia	1	65-74	3	Anaemia = Hb < 8	2
Complete/Catheterised	0	Discoloured (brusing/mottled)	2	75-80	4	Smoking	1
Incontinent urine	1			81+	5	**Neurological Deficit**	
Incontinent faeces	2	Broken (established ulcer)	3	**Nutritional Element**		Diabetes/MS/CVA Motor or sensory paraplegia (Max 6)	4-6
Doubly Incontinent (urine and faeces)	3	**Mobility**		Unplanned weight loss in past 3-6 months < 5% Score 0 5-10% Score 1 > 10% Score 2			
		Fully mobile	0				
Special Risks – Surgery/Trauma		Restless/Fidgety	1			**Special Risks - Medication**	
On table > 6 hours	8	Apathetic (sedated/depressed/ reluctant to move)	2			Cytotoxic, anti-inflammatory, long term/high dose steroids (Max 4)	4
Orthopaedic / below waist/Spinal (up to 48 hrs post-op)	5			BMI > 20 Score 0 BMI 18.5-20 Score 1 BMI < 18.5 Score 2			
On table > 2 hours (up to 48 hrs post op)	5	Bed bound (unconscious/unable to change position/traction)	4			Risk Score 10+ = 'At risk' 15+ = 'High Risk' 20+ = 'Very High Risk'	
		Chair Bound	5	Patient acutely ill or no nutritional intake > 5 days	2		

Patient's Initial Waterlow Score = If Score ≥10 Complete the Adapted Waterlow Pressure Area Risk Assessment Chart

PWA

NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

10

Affix Label

CHI: 1203893450

Royal Alexandra Hospital

Total Att: 76

12 Mth Att: 4

Title: MR

WEIR

James

DOB: 12/03/1989 Age: 29y Sex: Male

27D MACDOWALL STREET

Johnstone
Renfrewshire
PA5 8QJ
07377865873

Next of kin: WEIR, Deborah
Relationship: Sister
07474837113

GP: JC Sim
01505 321733

Attendance Date: 08/05/2018 Arrival Time: 17:39

Registration Time: 17:39 Date of Incident: 08/05/2018

Major Incident Desc:

Reason for Attendance: Erratic - with police

Affix Label

Nursing Assessment

Alerts: Not Recorded Allergies: Yes Pain Score:

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

Presenting Complaint:

Observation Date: 08/05/2018 17:48

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

Nurse name: Nurse Tracy Smith2

BM		mmol/L
PF		1/min
Expected PF		1/min
Weight		kg
Height		cm
Visual Acuity		
Left		
Right		
Corrected?		

GCS	
Eyes	
Motor	
Verbal	
Total	

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

Nursing Notes: "low mood, suicidal ideation. audio disturbances previous self harm. "

Child Assessment Questionnaire

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

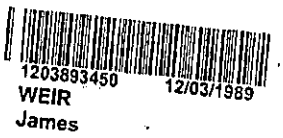
Discuss with Senior Medical Staff / Nurse on duty any factors identified

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

DO NOT WRITE HERE PLEASE

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

Date	CLINICAL NOTES
	Seen by (Dr) D ashton EM ST3 Time seen 19.45
8/5/18	3a pagen problems



Date	CLINICAL NOTES

Discharge Codes (Please CIRCLE)					Discharge date	
1. Admission	2. Discharge	3. Refer to GP	4. Transfer to other (see below)			
5. Died	6. Refer to OP Clinic (see below)		7. Irregular Discharge	8. D.O.A.	Discharge time	

Ward number (if admitted):	Transfer to hospital:	Consultant If admitted):

Follow up	Arranged	Not arranged	To be arranged

Clinic referred to	A&E	Hand injury	Fracture	Pop Check	Medical	Surgical	ENT	Others (specify):

Discharge Prescription Packs

Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Frequency	Signature	Given By

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

NHS Greater Glasgow & Clyde

1203893450 12/03/1989 r

WEIR

Patient name: James

CHI

Part One - Nursing Triage

triage nurse to complete this page

Triage Observations

document physiological measurements

GCS	BM	HR	BP	RR	SaO^2	Temp
15/15		86	136/62	16	95	36·2

accompanied by

name, relationship, particular concerns

Police
Blue Nike tracksuit Grey jacket Blue trainers

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

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

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

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

Outline of Presentation

tick all the categories which apply

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

Initial Presentation, Appearance and Behaviour

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

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

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

Triage Risk Assessment

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

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

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

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

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

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

Immediate management

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

Patient location, accompanied by... Police	Summary low mood suicidal ideation audio disturbance
Blood sample time?	
Toxbase info printed? Y/N	
GMAWS considered? Y/N	

name/grade

signature

date and time 08·05·18 1756

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Part Two - Mental Health Assessment

medical staff to complete this page

Patient name JAMES WER
CHI _____

outline of current presentation and precipitating factors

(29) Phonecall from police - concern raised about mental state.
Scared to go to own home because has been threatened by someone.
Police lading into threat and wanted attempting to release.
States thinks about suicide daily but doesn't as doesn't want to hurt nieces and nephews. Prev attempt to cut own throat - unsure when.
Nil plans of how to commit suicide.
States may try to kill himself via overdose if goes home, but not 100% certain, as when I asked would get CPN r/v he said that he wouldn't attempt suicide and "If I was going to I'd have done it by now".

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

ADHD
Depression
Anxiety
Personality disorder
PTSD

Prev victim of sexual abuse
Sees psychiatrist - unsure when next appt.
No longer has CPN as wouldn't attend appt.
ETOH x5
Smokes cannibus

Zopiclone
Clopramine
Mirtazapine

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

Has sister nearby - good relationship
Cares a lot for nephew
No relationship with mother, died in prison.

Appearance	Behaviour	Speech
clean	appropriate	normal
Mood	**Thought**	**Insight**
tearful		good

Risk Factors

(tick as appropriate, not exhaustive)

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

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

Risk Assessment

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

High / Moderate / Low

Discharge Advice and Plan for Further Assessment

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

summary	follow up and advice given
I advised Psych r/v but pt declined. Has capacity. DC	Advised to attend GP and contact Psych to expedite appt

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

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

name/grade D Annan
signature _____
date and time 08/5/18

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NEWS – National Early Warning Score

NHS
Greater Glasgow and Clyde

Name	
Address	
	1203893450 12/03/1989 WEIR James
CHI No.	
DoB	

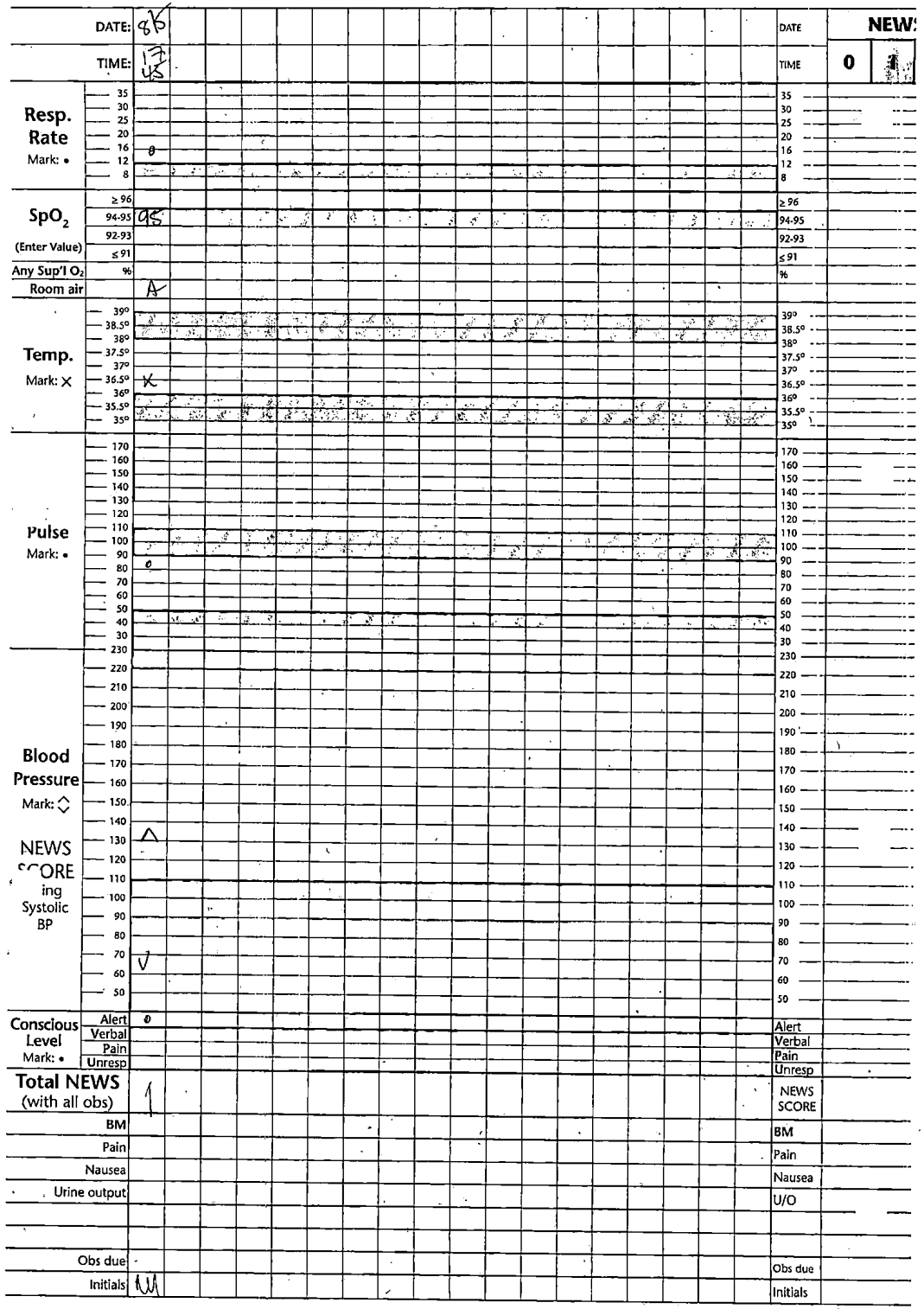
	Date	Ward
Admitted		
Transferred		
Transferred		

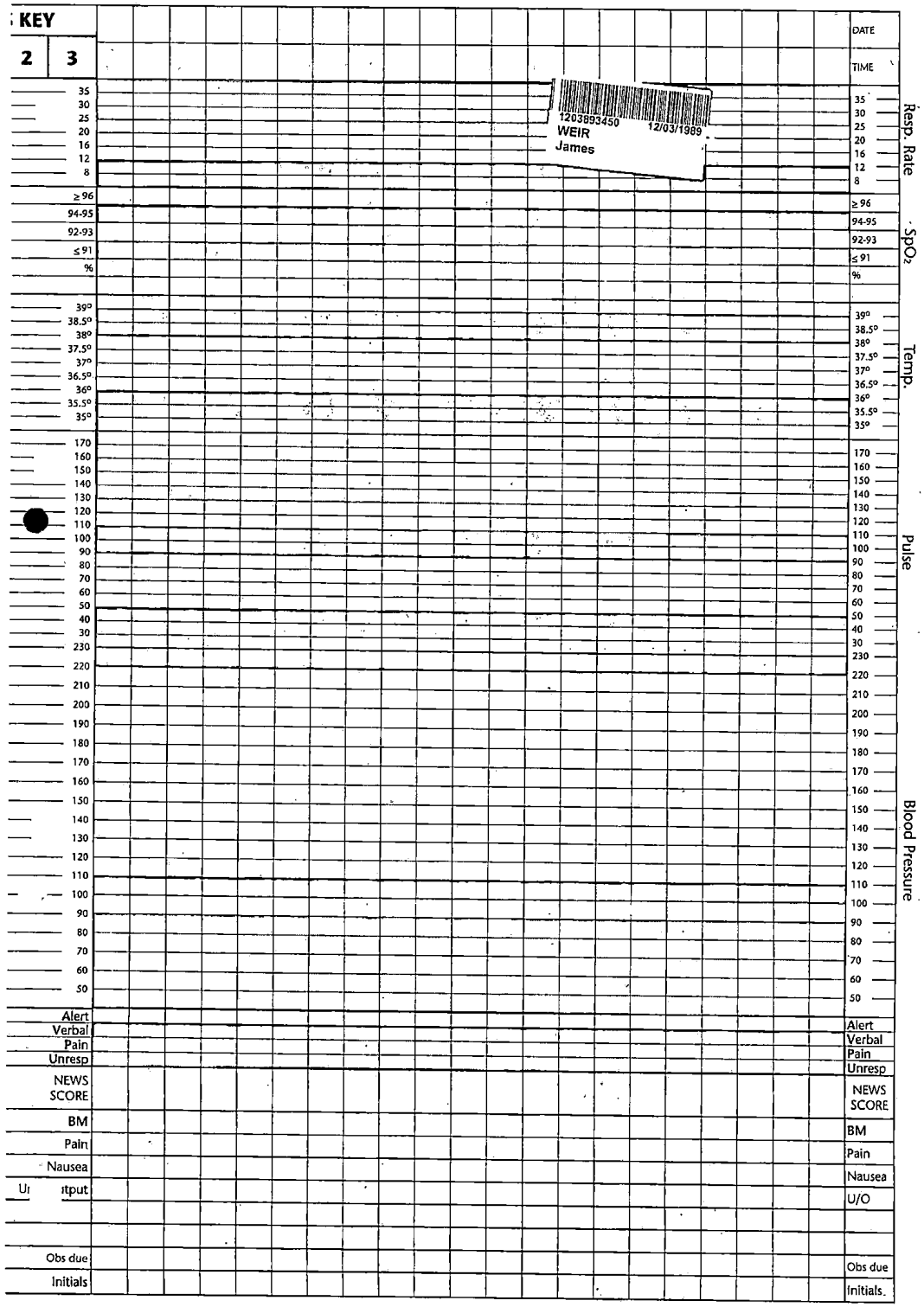
Physiological Parameter	NEWS – NHS Early Warning Score						
	3	2	1	0	1	2	3
Respiration Rate	≤8		9-11	12-20		21-24	≥25
Oxygen Saturations	≤91	92-93	94-95	≥96			
Any Supplemental Oxygen		Yes		No			
Temperature	≤35.0°		35.1-36.0°	36.1-38.0°	38.1-39°	≥39.1°	
Pulse	≤40		41-50	51-90	91-110	111-130	≥131
Systolic BP	≤90	91-100	101-110	111-219			≥220
Conscious Level				A			V, P or U

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

See NEWS Actions Reference Tool for local escalation policy

NEWS Score	Frequency of Monitoring	Clinical Response
0	Minimum 12 hourly	• Continue routine NEWS monitoring with every set of observations.
Aggregate 1- 4	Minimum 4 hourly	• Inform trained nurse. • Trained Nurse assessment: - Assess the patient - Review frequency of monitoring required - Assess need for escalation of clinical care and direct as appropriate.
Aggregate 5 or more or 3 in one parameter	Increased frequency to a minimum of 1 hourly	• Trained Nurse assessment. • Inform medical team caring for the patient. • Urgent assessment by a medical / surgical / nursing team with core competencies to assess acutely ill patients. • Consider level of monitoring required in relation to clinical care.
Aggregate 7 or more	Continuous monitoring of vital signs	• Trained Nurse to assess immediately. • Inform medical team caring for the patient – this should be at least senior medical staff level. • Emergency assessment by a clinical team with core competencies in the assessment of critically ill patients. This team will have critical care competencies and a practitioner/s with advanced airway skills and resuscitation skills. • Consider referral to high dependency or ITU.


DATE: 8/6
TIME: 17 45
DATE
NEW
TIME
0
1
Resp. Rate
Mark: •
35 30 25 20 16 12 8
SpO2
(Enter Value)
≥96 94-95 92-93 ≤91
Any Sup'l O2
%
Room air
Temp.
Mark: ×
39° 38.5° 38° 37.5° 37° 36.5° 36° 35.5° 35°
Pulse
Mark: •
170 160 150 140 130 120 110 100 90 80 70 60 50 40 30
Blood Pressure
Mark: ◇
NEWS SCORE ing Systolic BP
230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50
Conscious Level
Mark: •
Alert
Verbal
Pain
Unresp
Total NEWS (with all obs)
NEWS SCORE
BM
Pain
Nausea
Urine output
U/O
Obs due
Initials
IM


KEY
2
3
1203693450
12/03/1989
WEIR
James
DATE
TIME
Resp. Rate
SpO2
Temp.
Pulse
Blood Pressure
35
30
25
20
16
12
8
≥ 96
94-95
92-93
≤ 91
%
39°
38.5°
38°
37.5°
37°
36.5°
36°
35.5°
35°
170
160
150
140
130
120
110
100
90
80
70
60
50
40
30
230
220
210
200
190
180
170
160
150
140
130
120
110
100
90
80
70
60
50
Alert
Verbal
Pain
Unresp
NEWS SCORE
BM
Pain
Nausea
U/O
Obs due
Initials

Glasgow Coma Scale

Pupil size (mm): 1 • 2 • 3 4 5 | 6 7 8

Neurological Observations

| | | |

NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

2

Affix Label

Hospital (circle)	IRH	RAH	RHSC	GRI	WIC	VI	[illegible]	[illegible]	[illegible]

Royal Alexandra Hospital

CHI: 1203893450

Total Att: 75

12 Mth Att: 3

Title: MR

WEIR **James**

DOB: **12/03/1989** Age: **28y** Sex: **Male**

27D MACDOWALL STREET
Johnstone
Renfrewshire
PA5 8QJ
07377865873

Next of kin: **WEIR, Deborah**
Relationship: **Sister**
07474837113

GP: **JC Sim**
01505 321733

Attendance Date: **14/01/2018** Arrival Time: **17:29**

Registration Time: **17:29** Date of Incident: **14/01/2018**

Major Incident Desc:

Reason for Attendance: **mental health issues**

Affix Label

Nursing Assessment

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

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

Presenting Complaint:

Observation Date: **14/01/2018 17:44** Nurse name: **Nurse Gillian McGregor**

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

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

GCS	
Eyes	
Motor	
Verbal	
Total	

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

Nursing Notes: **"Brought to department by Police - allegedly violent and threatening harm to others. See mental health proforma. Patient states he has been sectioned x3. Last admitted to Dykebar hospital 1year ago. Aggressive in triage. Handcuffs in situ. Police in attendance. "**

Child Assessment Questionnaire

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

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

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

DO NOT WRITE HERE PLEASE

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

Date	CLINICAL NOTES
	Seen by (Dr) Time seen



1203893450 12/03/1989
WEIR
James

Date	CLINICAL NOTES

Discharge Codes (Please CIRCLE)					Discharge date	
1. Admission	2. Discharge	3. Refer to GP	4. Transfer to other (see below)			
5. Died	6. Refer to OP Clinic (see below)		7. Irregular Discharge	8. D.O.A.	Discharge time	

Ward number (if admitted):	Transfer to hospital:	Consultant If admitted):

Follow up	Arranged			Not arranged			To be arranged	
Clinic referred to	A&E	Hand injury	Fracture	Pop Check	Medical	Surgical	ENT	Others (specify):

Discharge Prescription Packs

Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Frequency	Signature	Given By

Emergency Department
Mental Health Triage and Risk Assessment

NHS Greater Glasgow and Clyde

Emergency Department Triage

Patient Name 1203893450 12/03/1989 WEIR James

DoB

Triage Observations

Document physiological measurements

GCS	BM	HR	BP	RR	SaO_2	Temp
15/15	5.3	95	117/66	18	96%	36.7c

Accompanied by

Name relationship particular concerns

Police. Black joggers Grey nike hoodie/grey jacket. Brown short hair.

Or describe the patient's physical appearance/clothing if attending alone as they may leave before assessment

Is the patient a young person in foster care or in a residential care placement? Yes/No

Is the patient a carer for a child or for a dependent adult? Yes/No

Is there a child protection concern or concern for an adult at risk? Yes/No

Outline of Presentation

Circle those responses which apply and provide brief summary

Overdose – will require medical assessment		Police contacted by concerned members of public Aggressive & threatening
Self-Injury - will require wound management		
Other Mental Health Presentation	✓	

Initial Presentation, Appearance and Behaviour

Respond Yes/No to each question and circle appropriate response

Is the patient violent, aggressive or threatening?	Yes		No
Is the patient obviously distressed, markedly anxious or highly aroused?		Yes	No
Is the patient quiet and withdrawn?		Yes	No
Do you think the patient is behaving inappropriately to their situation?		Yes	No
Do you think the patient presents an immediate risk to you, to others, or to themselves?	Yes		No
Do you think the patient is likely to abscond prior to assessment?	Yes		No
Do you think the patient's presentation suggests either delusions or hallucinations?*	Yes		No
Do you think the patient's presentation suggests they feel their actions are being controlled?	Yes		No
Are you aware of a history of mental health problems or psychiatric illness?		Yes	No
Are you aware of a history of violence or self harm?		Yes	No
Is the patient currently expressing suicidal thoughts	Yes		No

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

Triage Risk Assessment

Indicate additional care for risk by circling one and deducting circle for risk

High/Moderate/Low Risk

of self-harm/violence/absconding in department

Triage Category		
	2	high risk – supervised *and* in the department
		moderate risk – supervised *or* in the department
		low risk – can be asked to wait if necessary

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

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

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

Immediate Management

Print toxbase information and paracetamol overdose document 4hour time for sample

Patient location, supervised by...	AWA – police		
Blood sample time?		Toxbase Information Printed?	

Print Name G. McGREGOR

Signature

Date 14/1/18 Time 1745

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Emergency Department Mental Health Assessment

To be completed by medical staff

Outline of current presentation and precipitating factors

Previous mental health problems, self harm, addictions, medication etc

Other relevant information; relationships, finances, employment, housing, physical health, childcare etc

Appearance	Behaviour	Speech
Mood	Thought	Insight

Risk Assessment

Evaluation of clinical risk, current indicators, category, potential for further episodes of self-harm in the short-term, factors to consider in any protective as well as precipitating factors

High/Moderate/Low

Risk Factors (y/n/unknown)			
male gender	y	n	u
age >18 and <65	y	n	u
depression	y	n	u
alcohol or drug use	y	n	u
separated, widowed, divorced	y	n	u
suicide plan/concealment	y	n	u
evidence of psychosis	y	n	u
ongoing suicial intent	y	n	u
lack of social support	y	n	u
chronic physical illness/pain	y	n	u
family history of suicide	y	n	u
family concerned about risk	y	n	u
disengaged/poor compliance	y	n	u
unemployed or retired	y	n	u
access to lethal means of harm	y	n	u
previous violent methods	y	n	u
history of self harm/overdose	y	n	u
previous psychiatric treatment	y	n	u
current psychiatric treatment	y	n	u
current use of benzodiazepines	y	n	u

Summary and Plan for Further Assessment

Referral to: liaison psychiatry, GP, doctor, ORN service, CMHT, CP, addiction services, SW, etc

Summary

Service Referred to	Time of Referral

Discharge

Indicate the follow-up plan advice given and identify who was informed of the decision

Follow up and advice	Carer informed

Name and Designation of Consultant or Middle-Grade Involved in Reviewing Patient	

If young people in foster or residential care are assessed, their social work team should be informed, (via standby SW if out-of-hours), *and* correspondence given to carers present.

Print Name _____

Signature _____

Date & Time _____

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version 2.0 – February 2013

Emergency Department Nursing Documentation

NHS Greater Glasgow and Clyde

Patient Address Label
1203893450 12/03/1989
WEIR
James

Presenting Complaint: MENTAL HEALTH ISSUES

Date and Time: 15.1.18 1800

Named Nurse(s):

Patient preparation (Please tick when completed)	Initials: AD
Prepare patient for examination and provide blankets if required	☑
Clothing bagged, labelled and stored under trolley	☑
Name-band (if required) PENICILLIN	☑

Communication (Please tick when completed)	Initials: AD
Communication Aids (spectacles / hearing aid)	☐
Relatives present, who?	☐
Relatives / NOK informed POLICE	☑
Interpreter required	☐
Telephone interpretation required	☐

Observations and Investigations (Please tick when completed)		Initials:	
Vital Signs recorded on NEWS chart and NEWS score recorded. Record Pain, blood sugar and neuro obs on NEWS chart if appropriate.	☑	IV cannula (if required)	☐
Peak Flow 1. 2. 3.	☐	Blood samples taken	☐
12 Lead ECG	☐	Urinalysis and Specimen if indicated *Results:*	☐
Cardiac Monitoring	☐		
X-rays performed	☐	HCG specimen if indicated +ve ☐ -ve ☐ Strip Lot no:	☐
Other: please add	☐	Weight:	☐

Screening Tools (Please circle or tick as appropriate)		Initials: AD	
SEPSIS risk? SIRS Criteria 2 or more and suspicion of infection Sepsis 6 protocol initialise and departmental documentation started	Y (N) Y / N	**Preliminary Pressure Ulcer Risk Assessment** The patient can reposition themselves whilst in the department?	(Y) N
AMT 4 (if >65 years) SCORE	/4	There is **no** reported skin damaged other than presenting trauma?	(Y) / N
At risk of falls? (clinical judgement) (consider alcohol, mobility, age, illness, cognitive impairment etc). *If at risk complete risk assessment*	Y (N)	The person is fully continent? *If NO to any of the above initiate Waterlow risk assessment (within 4 hrs)*	(Y) N
Mental Health Triage Assessment	(Y) N	**Waterlow Score** *If >10 commence Active Care*	☐
Child Protection considered (in line with policy)	Y (N)	**Active Care** (clinical judgement) (include all trolley patients at risk of pressure ulcers and all trolley patients in department for >4hrs) *Record on Active Care Chart*	☐
FAST	Y (N)		
GMAWS	Y (N)	Pressure damage identified on arrival in ED is documented in clinical notes	☐
Has Swallow test been carried out?	Y (N)	Grade 3 or 4 Pressure Ulcers are reported on DATIX	☐

Pause for Transfer (Please tick when completed)		Tick when completed	N/A	Notes
	Relatives informed	☐	☐	Information on discussion with relatives
	Cannula	☐	☐	
	Name band	☐	☐	
	AMT4	☐	☐	
	NEWS chart NEWS >7 - Name and Page number of senior doctor caring for patient	☐	Always	
Prescriptions signed	Infusions	☐	☐	
	Drugs	☐	☐	
	Allergies are recorded (e.g. on Kardex)	☐	☐	
	Fluids	☐	☐	
	Two hour plan in place e.g. Fluids, Antibiotics and emergency drugs written up on Kardex	☐	☐	
	GMAWS	☐	☐	
	Belongings (including patient's medications)	☐	Always	Please note here if any other tasks required prior to transfer
	Bed requested, accepted and ward informed	☐	Always	
	Notes: medical notes, GP letter, PRF	☐	Always	
Investigations	CXR reviewed	☐		
	ECG reviewed	☐	☐	Print name
	Bloods sent	☐	☐	
	Bloods reviewed	☐	☐	
	Patient on O_2: cylinder checked	☐	☐	
	Patients requiring analgesia: sufficient	☐	☐	

Patient Addressograph Label

1203893450 12/03/1989
WEIR
James

Pause for Discharge (Please tick when completed)	Tick when completed	N/A	Notes
Advice leaflets given	☐	☐	Information on discussion with relatives
Belongings (including patient's medications)	☐	Always	
New medications explained	☐	☐	
Cannula removed	☐	☐	
Relatives aware of discharge	☐	☐	Please note here if any other tasks required prior to discharge
Social/ Support Services required and contacted	☐	☐	
SAS transport required and ref no	☐	☐	Print name
Other means of transport arranged by nurse	☐	☐	

Nursing Notes and Care Plan

Date and Time		Print Name and Signature
1805	INTO ROOM FOR EXAM POLICE IN ATTENDANCE, VERBALLY AGRESSIVE. SCREAMING + SHOUTING.	
1810	REMOVED FROM DEPT BY POLICE	

JAMES WEIR
1203893450

Patient Addressograph Label

Nursing Notes and Care Plan

Date and Time		Print Name and Signature

Emergency Department - Active Care

I have evaluated and deemed that the frequency of care delivery over the next work shift, based on the patient's most critical need should be every:

(Please circle) ½ hour 1hour 2 hours

Signed ..... Name .....

USE FOLLOWING CODE:

O = Off the ward V = Variant S = Sleeping I = Independent NT = No Thanks

Patient Addressograph Label

			Time							
	1.	**PAIN: Assess and address** If in pain inform registered nurse **Y/ N or N/A**								
S	2.	**SKIN INSPECTION** Pressure areas checked: **Y / N / I (independent)**								
		Redness (R) / Discolouration (D) / Pressure Ulcer (PU) / Intact (INT)								
K	3.	**KEEP MOVING:** Have you moved or walked **Y / N / I (independent)**								
		Bed Right side (30° tilt) – R Left Side (30° tilt) – L Back– B								
		Chair Assist to walk, stand or tilt (W /ST/ T)								
I	4.	**ELIMINATION:** Do you need the toilet? I = Independent A = Assistance given IC = patient incontinent of urine/faeces								
N	5.	**FOOD, FLUIDS AND NUTRITION:** Is the patient nil by mouth? **Y / N** (consider mouth care)								
		Encourage the patient to drink? **(if appropriate) Y / N / N/A**								
		Food, snack or supplement taken? **(if appropriate) Y / N / N/A**								
	6.	**ENVIRONMENT:** Is the patient able to call for assistance? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position? **Y / N**								
	7.	**INFORMATION:** Ask: Is there anything else I can help you with? Inform patient of the time of return. **Y / N**								
	8.	**ESCALATION:** Escalate any issues to the Registered Nurse? **Y / N/A**								
			Nurse Initials							

USE FOLLOWING CODE	Specialist Pressure Redistributing equipment	Variations			
V = Variant **I = Independent** **NT = No thanks**	☐ Repose Mattress ☐ Moving and handling aids ☐ Other:	Time	No.	Variation	Signed

Waterlow Pressure Area Risk Assessment

Build/Weight		Skin Type/Visual Risk Areas		Sex/Age		Special Risks – Tissue Malnutrition	
Average (BMI 20-24.9)	0	Healthy	0	Male	1	Multiple organ failure/ Terminal cachexia	8
Above Average (BMI 25-29.9)	1	Tissue Paper (thin/fragile)	1	Female	2		
Obese (BMI > 30)	2	Dry (appears flaky)	1	14-49	1	Single organ failure	5
Below Average (BMI < 20)	3	Oedematous (puffy)	1	50-64	2	Peripheral Vascular Disease	5
Continence		Clammy /pyrexia	1	65-74	3	Anaemia = Hb < 8	2
Complete/Catheterised	0	Discoloured (brusing/mottled)	2	75-80	4	Smoking	1
Incontinent urine	1			81+	5	**Neurological Deficit**	
Incontinent faeces	2	Broken (established ulcer)	3	**Nutritional Element**		Diabetes/MS/CVA Motor or sensory paraplegia (Max 6)	4-6
Doubly Incontinent (urine and faeces)	3	**Mobility**		Unplanned weight loss in past 3-6 months < 5% Score 0 5-10% Score 1 > 10% Score 2			
Special Risks – Surgery/Trauma		Fully mobile	0			**Special Risks - Medication**	
On table > 6 hours	8	Restless/Fidgety	1			Cytotoxic, anti-inflammatory, long term/high dose steroids (Max 4)	4
Orthopaedic / below waist/Spinal (up to 48 hrs post-op)	5	Apathetic (sedated/depressed/ reluctant to move)	2	BMI > 20 Score 0 BMI 18.5-20 Score 1 BMI < 18.5 Score 2			
On table > 2 hours (up to 48 hrs post op)	5	Bed bound (unconscious/unable to change position/traction)	4			Risk Score 10+ = 'At risk' 15+ = 'High Risk' 20+ = 'Very High Risk'	
		Chair Bound	5	Patient acutely ill or no nutritional intake > 5 days	2		

Patient's Initial Waterlow Score = If Score ≥10 Complete the Adapted Waterlow Pressure Area Risk Assessment Chart

NEWS – National Early Warning Score

NHS
Greater Glasgow and Clyde

Name
Address

1203893450 12/03/1989
WEIR
James

CHI No.
DoB

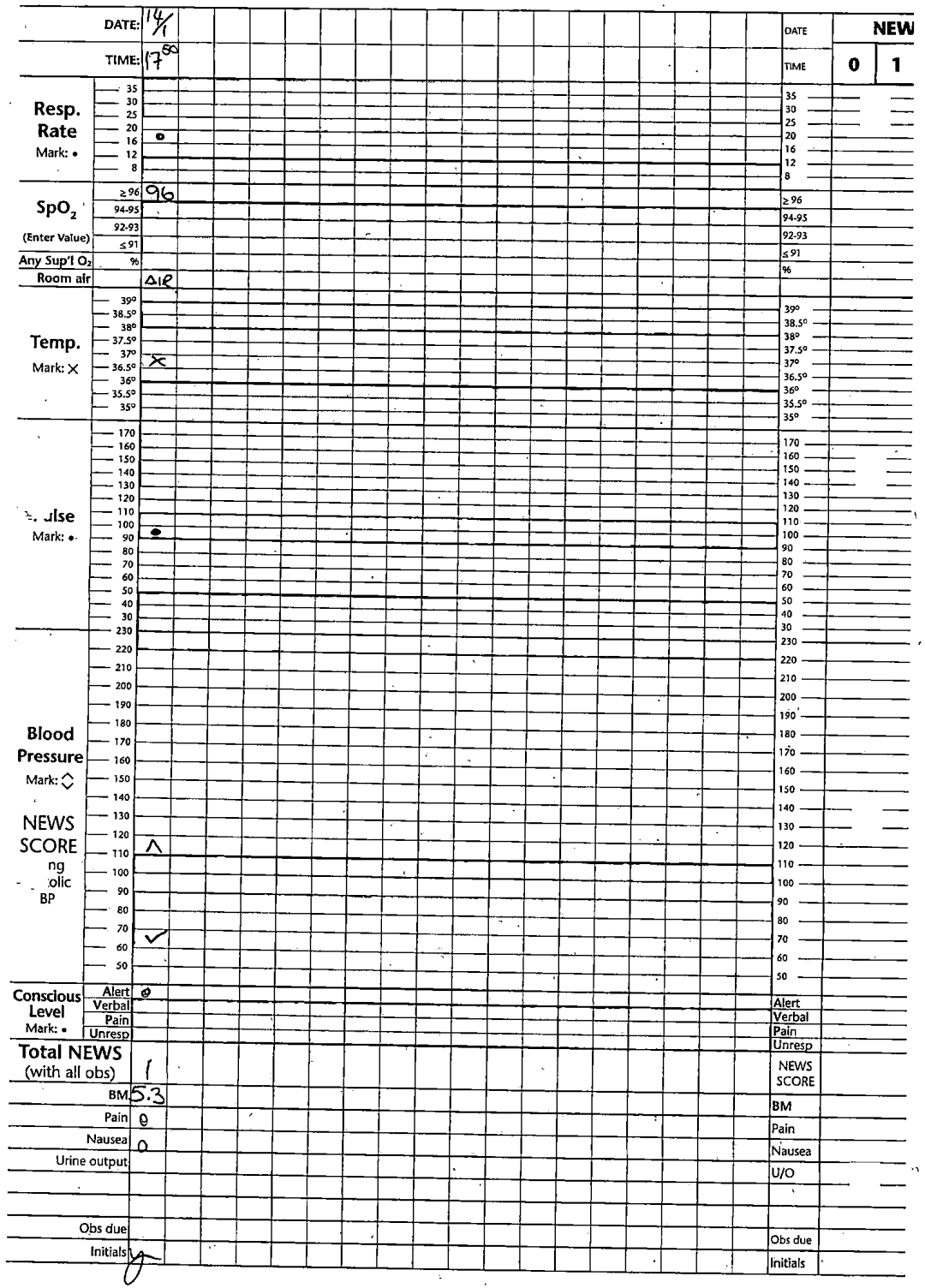
	Date	Ward
Admitted	14/11/18	A+E
Transferred		
Transferred		

Physiological Parameter	NEWS – NHS Early Warning Score						
	3	2	1	0	1	2	3
Respiration Rate	≤8		9-11	12-20		21-24	≥25
Oxygen Saturations	≤91	92-93	94-95	≥96			
Any Supplemental Oxygen		Yes		No			
Temperature	≤35.0°		35.1-36.0°	36.1-38.0°	38.1-39°	≥39.1°	
Pulse	≤40		41-50	51-90	91-110	111-130	≥131
Systolic BP	≤90	91-100	101-110	111-219			≥220
Conscious Level				A			V, P or U

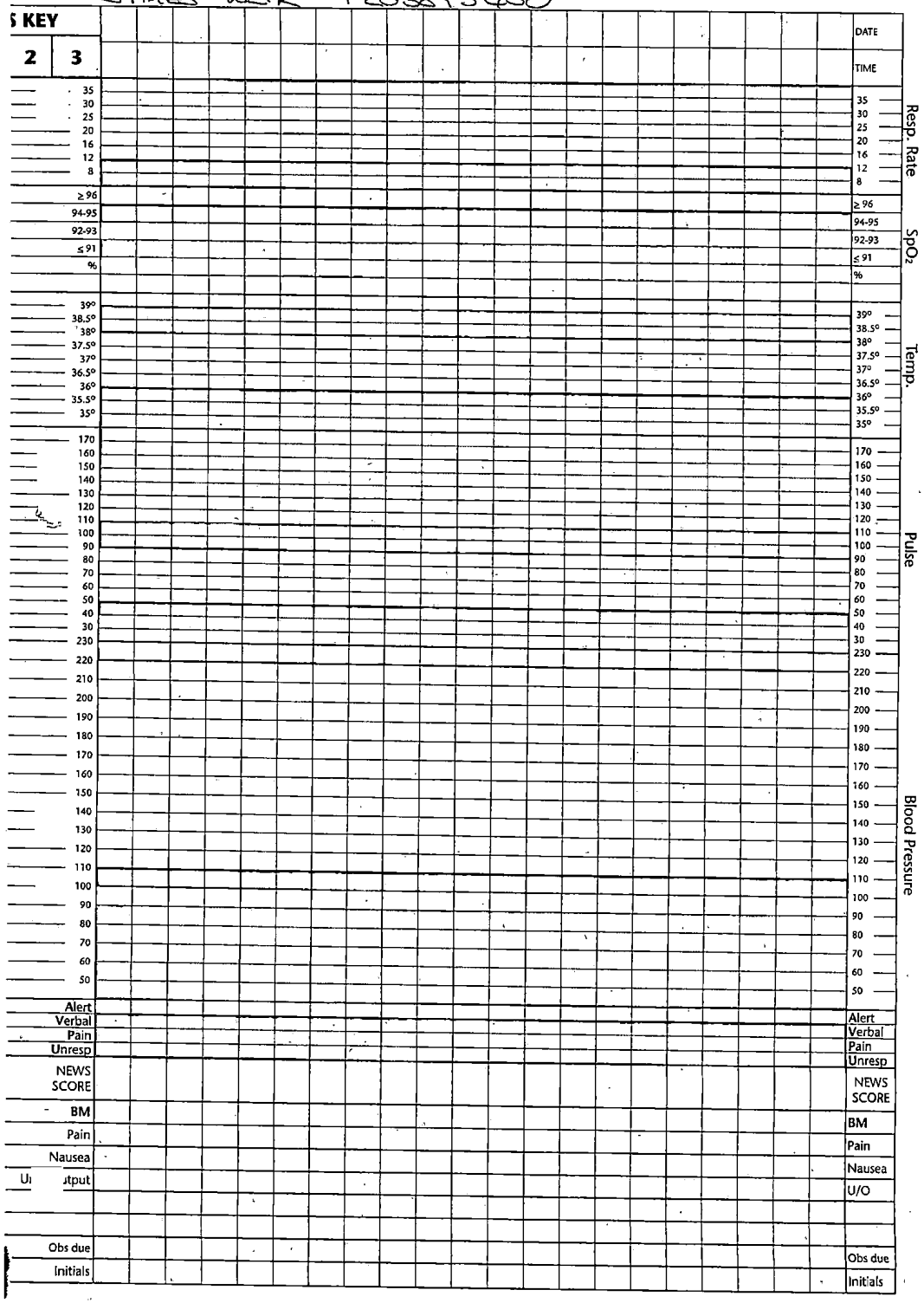
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See NEWS Actions Reference Tool for local escalation policy

NEWS Score	Frequency of Monitoring	Clinical Response
0	Minimum 12 hourly	• Continue routine NEWS monitoring with every set of observations.
Aggregate 1- 4	Minimum 4 hourly	• Inform trained nurse. • Trained Nurse assessment: - Assess the patient - Review frequency of monitoring required - Assess need for escalation of clinical care and direct as appropriate.
Aggregate 5 or more or 3 in one parameter	Increased frequency to a minimum of 1 hourly	• Trained Nurse assessment. • Inform medical team caring for the patient. • Urgent assessment by a medical / surgical / nursing team with core competencies to assess acutely ill patients. • Consider level of monitoring required in relation to clinical care.
Aggregate 7 or more	Continuous monitoring of vital signs	• Trained Nurse to assess immediately. • Inform medical team caring for the patient – this should be at least senior medical staff level. • Emergency assessment by a clinical team with core competencies in the assessment of critically ill patients. This team will have critical care competencies and a practitioner/s with advanced airway skills and resuscitation skills. • Consider referral to high dependency or ITU.


DATE: 14/1
TIME: 1750
Resp. Rate
Mark: •
35
30
25
20
16
12
8
SpO2
(Enter Value)
≥96
94-95
92-93
≤91
96
Any Sup't O2
%
Room air
AIR
Temp.
Mark: X
39°
38.5°
38°
37.5°
37°
36.5°
36°
35.5°
35°
X
Pulse
Mark: •
170
160
150
140
130
120
110
100
90
80
70
60
50
40
30
230
220
210
200
190
180
170
160
150
140
130
120
110
100
90
80
70
60
50
Blood Pressure
Mark:
NEWS SCORE
ng
olic
BP
Conscious Level
Mark: •
Alert
Verbal
Pain
Unresp
Total NEWS (with all obs)
1
BM
5.3
Pain
0
Nausea
0
Urine output
Obs due
Initials
DATE
TIME
NEW
0
1
NEWS SCORE
BM
Pain
Nausea
U/O
Obs due
Initials

JAMES WEB 1203893450



Glasgow Coma Scale

Pupil size (mm)

1	2	3	4	5	6	7	8
•	•						

Neurological Observations

Date:				14/1																								
Time:				1750																								
COMA SCALE	E Eyes open	Spontaneously	4	4																								Eyes closed by swelling = C
		To speech	3																									
		To pain	2																									
		None	1																									
	V Best Verbal response	Orientated	5	5																								Endotracheal tube or tracheostomy = T
		Confused	4																									
		Inappropriate words	3																									
		Incomprehensible sounds	2																									
		None	1																									
	M Best motor response	Obeys	6	6																								Usually record the best arm response
		Localises	5																									
		Flexion - withdrawal	4																									
		Flexion - abnormal	3																									
		Extension to pain	2																									
		None	1																									
	TOTAL SCORE			15																								
PUPILS	R	Size																										+ reacts – no reaction c. eyes closed
		Reaction		+																								
	L	Size		+																								
		Reaction		+																								
LIMB MOVEMENT	ARMS	Normal power		6																								Record right (R) and left (L) separately if there is a difference between the two sides
		Mild weakness																										
		Severe weakness																										
		Spastic flexion																										
		Extension																										
		No response																										
	LEGS	Normal power		6																								
		Mild weakness																										
		Severe weakness																										
		Spastic flexion																										
		Extension																										
		No response																										

Pain Score

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

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

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

Management Plan and Patient Exclusions

Date and Time	Notes	Signed

Emergency Attendance Letter

NHS
Greater Glasgow and Clyde

Emergency Department
Royal Alexandra Hospital
Corsebar Road
Paisley
Renfrewshire
PA2 9PN

Dept. Contact Details:
Tel:
Fax: Patient attended the
Email: Medical Assessment Unit

Date Completed: 24/07/2017

Consultant: Dr Iain Keith

JC Sim
Quarryside Practice
Linden Medical Centre
25 Floors Street
Johnstone
Johnstone
PA5 8PZ

Dear JC Sim

Re: **Weir James** DOB: **12/03/1989** CHI: **1203893450**
27D MACDOWALL STREET
Johnstone PA5 8QJ

Attended on: **24/07/2017 at 17:08 hrs.** Departed on: **24/07/2017 at 20:06 hrs.**
Discharge Type: **01a - Discharge with no follow up** Destination: **Private residence**
Previous ED Attendance in last 12 months: **5**

Presenting complaint
Chest Infection

Nursing Assessment:

Investigations in ED:

1. Amylase	**2. D - Dimer**	**3. Coagulation screen**
4. Urea and Electrolytes	**5. Glucose**	**6. LFT**
7. CRP	**8. Chol / Triglyceride**	**9. Full Blood Count**
10. Troponin I hs	**11. Blood Culture**	**12. XR Chest**

Diagnosis:

Diagnosis	Side	Site
Viral infection, unspecified		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:

Primary and Important Co-Morbidities - Viral LRTI. Presenting symptoms - 6 Day history of some chest tightness. Had some pins and needles in hands. Today had half a bottle of buckfast. No other associated symptoms. Investigation results - Bloods unremarkable, Trop I negative, D-dimer negative Inflammatory markers normal. ECG Nil acute. CXR Nil focal. Management - Discharged home. Advised to take simple analgesia and fluids. Changes to medication - Nil Follow up and outpatient investigations - Nil

Followup :

Highly sensitive: N

Consent for sharing withheld: N

Yours sincerely,
Stephen Paterson
Nurse

Copies to:

1. JC Sim (GP)

School Address:

QUARRYSIDE PRACTICE

Dr. Graeme K. Harris

Dr. Jacqueline E. Webb

Dr. Ali Raji

Dr. Juliet Sim

Linden Medical Centre
25 Floors Street
Johnstone
PA5 8PZ

Tel: (01505) 321733/324249 Fax: (01505) 800997
www.quarrysidepractice@ggc.scot.nhs.uk

James Tho. Weir
27d Macdowall Street
JOHNSTONE
PA5 8QJ

CHI: 1203893450 12/03/1989 M
WEIR, James Thomas
27d Macdowall ,PA5 8QJ

Dr. G.K. Harris, 2555320
Quarryside Practice, PA5 8PZ
24/07/2017 16:01. Practice: 87305

24/7/17

Dear Dr

Thanks for seeing this 28 year old man. He was up in the north west highlands last week on an outdoor course and started having chest pain about 5-6 days ago. This has worsened over the weekend with accompanying faintishness & sensation of mild breathlessness. The pain is felt in the middle of the anterior chest & high epigastrium, & seems aggravated by deep inspiration & laughing. Eating has not been affected, & does not change his pain.

He has a past history of depression & alcohol & drug misuse but has been doing well in the last few weeks. He had some Buckfast however this morning. He has a past H/O gastritis, &

I note he had pericarditis in 2012.

He had some episodes of haemoptysis in May ? a normal CXR in early May.

O/E. T37.9. p120, reg. BP 110/70. O2 sat 96.

Hs normal.

chest clear but AE not great.

Tender in epigastrium.

A. ? Acute liver resp. Tract infection.

PMH
Meds. > see attached.

Yours sincerely

Graeme Hanson.

Registration Details - Patient No: 9202

Personal details...		Address details...	
Date of birth	12/03/1989	Post Code	PA5 8QJ
Sex	M	House Name Flat No	
Surname	Weir	No and Street	27d Macdowall Street
Previous Surname		Village	
Forenames	James Thomas	Town	JOHNSTONE
Calling Name	James	County	RENFREWSHIRE
Title	Mr		
Birth Surname			
Marital Status			
Ethnic Origin			

HA/HB Details...		Contact details...	
Trading partner	Argyll & Clyde	Home Tel No	
Registered GP	Dr Juliet Sim	Work Tel No	
Usual GP	Dr Juliet Sim	Mobile Tel No	07397 108505
Residential Inst		E Mail Address	
Branch Surgery	Quarryside Practice	Next of Kin	
CHI Number	1203893450	Next of Kin Contact No	
NHS Number			

Practice Information...		Distances	
Dispensing		Rural Mileage	
Hospital Number		Blocked Special	
Records At		Walking Quarters	

Further Information		Upload Consent	
Long/Short stay or Dead		SCI-DC Consent	Implied Consent (default)
Date of registration	12/12/2016		

AMS\CMS Details		Imported user defined fields	
AMS Consent	Yes	Contact	
Pharmacy Details		Contact Relationship	
Item Collected Check	No	Pharmacy Name	
CMS Suitability Status	-1	Pharmacy Address	
CMS Registration Status	1		

Medical Record

Problems

Active Problems		Authorised By	Code
27/01/2017	Benzodiazepine dependence detoxification residential	Dr Renwick	8BAo
11/08/2015	[D]Collapse ?alcohol or drug related; absconded from hospital	Dr Harris	R0023
22/05/2015	Gastritis unspecified	Mr Glass	J155
22/05/2013	History of sexual abuse	Mr Glass	14X1
17/01/2011	Neurotic depression reactive type	Mr Glass	E204
01/01/2006	Alcohol problem drinking	Mr Glass	E23-2
01/01/1997	[X]Attention deficit disorder	Mr Glass	Eu9y7

Past Problems		Authorised By	Code
18/09/2016	Benzodiazepine dependence detoxification	Dr Harris	8BAo
11/08/2016	[X]Adjustment disorders	Ms Ferguson	Eu432

11/08/2016	**Suicidal ideation**	Ms Ferguson	1BD1
03/11/2015	**Fracture of metacarpal bone (Right)** closed fracture of metacarpal bone. Right hand base 4th metacarpal	Mrs Grose	S25
22/05/2015	**Gastroscopy NEC** gastritis	Mr Glass	761Fz-1
19/07/2013	**A&E attendance** suicidal thoughts	Mr Glass	EMISNQAE1
20/05/2013	**A&E attendance** police concern over suicidal intent	Mr Glass	EMISNQAE1
08/04/2013	**Gastroscopy NEC** duodenitis	Mr Glass	761Fz-1
03/04/2013	**Emergency hospital admission** epigastric pain and vomitting	Mr Glass	8H2
09/11/2012	**Primary repair of inguinal hernia (Left)**	Mr Glass	7H11
03/10/2012	**Acute pericarditis**	Mr Glass	G50
16/08/2012	**Inguinal hernia**	Mr Glass	J30
01/01/2012	**Death of mother** RTA	Mr Glass	13M8
23/12/2011	**[X]Assault** facial injury	Mr Glass	U3
13/10/2011	**Overdose of drug** paracetamol	Mr Glass	SL-5
21/06/2011	**[X]Intentional self poisoning/exposure to noxious substances** paracetamol overdose	Mr Glass	U20
01/01/2011	**Death of father** RTA	Mr Glass	13M7
02/11/2010	**Hydrocele (Left)**	Mr Glass	K23
01/02/2010	**Prison sentence**	Mr Glass	13HQ-2
07/10/2009	**Other primary open reduction of fracture of bone** right tibial plateau	Mr Glass	7K1G
07/10/2009	**Closed fracture proximal tibia, lateral condyle (plateau) (Right)**	Mr Glass	S3304
07/09/2009	**Closed fracture shaft of fibula (Right)**	Mr Glass	S3321
01/02/2008	**[X]Intentional self poisoning/exposure to noxious substances** ate noxious substance	Mr Glass	U20
01/09/2007	**[X]Overdose - paracetamol**	Mr Glass	U200-1
01/08/2007	**[X]Overdose - paracetamol**	Mr Glass	U200-1
01/03/2007	**Laceration of arm (Left)**	Mr Glass	S9-1
01/01/2007	**[X]Accidental drug overdose / other poisoning** secondary to alcohol	Mr Glass	U1A-2
01/01/2007	**Dental abscess**	Mr Glass	J0250
01/01/2006	**[X]Overdose - paracetamol** accidental	Mr Glass	U200-1
01/01/2006	**Intoxication - alcohol** /collapse (x4)	Mr Glass	E250-4
01/11/2005	**Closed reduction of fracture** of orbit bone - assault	Mr Glass	82-1
01/01/1998	**Suicide + selfinflicted poisoning by drug or medicine NOS** loperamide	Mr Glass	TK05
01/01/1996	**[V]Behavioural problems**	Mr Glass	ZV40-1
01/01/1990	**O/E - failure to thrive**	Mr Glass	22I2
01/08/1989	**On child protection register** removed in 1990; older sibling 'cot death', 2 other siblings adopted	Mr Glass	13Id

Alerts		Authorised By	Code
17/03/2015	**Alert** must only been seen by a partner	Miss McCracken	EMISALERT

Drug Allergies		Authorised By	Code
	None		

Non Drug Allergies		Authorised By	Code
	None		

Health Status		
08/04/2015	**Height 176 cm**	
08/04/2015	**Weight 58 Kg**	
08/04/2015	**Body Mass Index 18.72 kg/m2**	
24/02/2016	**Blood pressure reading** O/E - BP reading	
24/02/2016	**Blood pressure reading 110/74 mm Hg**	
28/10/2015	**Smoking Status Current smoker**	
08/04/2015	**Alcohol consumption 20 units/week**	
08/04/2015	**Exercise grading Aerobic exercise 0 times/week**	

Consultations

24/07/2017 14:46 Dr GK Harris at Phone Encounter

History Persistent lower chest/upper abd pain about 6 days, seems to be getting worse. Has had some Buckfast today. Started whilst away on an outdoor course-was doing a lot of hillwalking. Appointment today given.

Medication

Current Date Commenced	Drug Details	Date Last Issue	Authorised By	Type
29/06/2017	**Chlorpromazine Hydrochloride Tablets 25 mg** 1 TAB PRN UPTO 6 TABLETS PER DAY 112 tablet	29/06/2017P	Dr Ali Raji	ACUTE
29/06/2017	**Mirtazapine Tablets 45 mg** ONE TO BE TAKEN AT NIGHT 28 TABLET	29/06/2017P	Dr Ali Raji	ACUTE

Cycle 20

NHS
Greater Glasgow and Clyde

Acute Medical Unit Admission Proforma

MAU/A&E/AMU

Royal Alexandra Hospital, Paisley/Vale of Leven Hospital/IRH

Patient Details		
Name: **Address:**	1203893450 WEIR M James 12/03/1989 27D MACDOWALL STREET Johnstone, Renfrewshire PA5 8Q	**Sex:** F ☐ M ☑ **DoB** __/__/__ **Age:** 28
Telephone:		
GP:		
Next of Kin:		
Telephone:		

Episode Details			
Date patient seen:	24/7/17	**Time seen:**	
Source of referral:	GP ☑ A&E ☐ OPD ☐ Self ☐ Other =		
Admitting Dr:	S. Paterson	**Grade** SHO	**Bleep** 5626
Consultant:			5624

Resuscitation Decision

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

Signature: _____ **Name:** _____ **Grade:** _____

If DNA CPR → Complete appropriate form

Cycle 20

Presenting Complaint(s)	
Presenting complaint	Central chest Pain.
History of presenting complaint	6 Day history of central chest pain. Started whilst in west highlands whilst walking. Describes it as a tightness has some pins & needles in both hands. °SOB °Palpitations °Syncope °nausea. Had ½ bottle of Buckfast today. Denies any substance abuse with exception of Cannabis. Multiple toxicology on Postal all only Cannabis. Admits Alcohol & Cannabis excess in past. Extremely Anxious at present.

Past Medical History / Review of Old Notes. Review eKIS if available
Previous Alcohol dependency. OD. Gastritis Pancreatitis. Epigastric pain. Pericarditis Inguinal Hernia.

Systemic Enquiry				
Resp	CVS	GI	GU	CNS
°SOB	Pain	°Abd Pain		Nil
°Cough	°Syncope	°Nausea		
°Sputum	°Palpitations			

Cycle 20

MEDICINES RECONCILIATION – Acceptable to staple fully completed Emed Rec

Source of medication history Patient ☑ Relative/carer ☐ GP Phone call ☐ ECS ☑

(>1 source preferred) Patient own drugs ☐ Com. Pharmacist ☐ GP letter/summary ☐ Repeat Script ☐

Other (please specify) .....

Admission Medicines	Dose	Frequency	Plan for medicines (Dr complete) Continue	Amend	Withold	Stop	Comments Reason for alteration
Chlorpromazine	25mg	OD PRN.	✓				
MIRTAZAPINE	45	nocte.	✓				

Allergies

None known ☑

List any over-the-counter or alternative medicines

Do medicines need further clarification ? Yes ☐ No ☐

List collected by : S. Pearson.

Designation : ANP Date : 24/7/17

Plan approved by :

Designation : Date :

Pharmacy review

Comments

Compliance aid : Yes ☐ No ☐

Community pharmacist Phone

Reviewed by : Designation : Date :

Cycle 20

Social History

Smoking History

Ex-smoker / Smoker 10 cpd ___yrs Never smoked

Alcohol History

___ Units/week FAST score if excess ___

½ Bottle Buck fort today Stubbs only occassional.

Recreational Drugs Driving Status

Cannabis. Yes.

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

L.

Family History

Observations

RR: 18 bpm **Sats:** 96 % **FiO2:** RA **Temp:** 37.4 °C **BP:** 117/65 **HR:** 113 bpm **BM:**

General Examination

General Appearance:

Cyanosis / pallor / jaundice / clubbing / lymphadenopathy

Respiratory

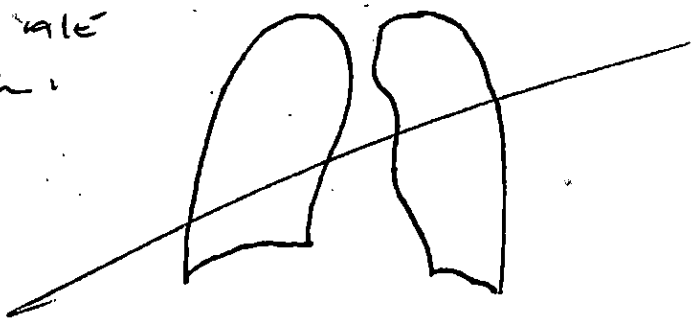
PEFR =

Frequent male

Vesicular

°Cough

°Sputum



Cycle 20

Cardiovascular

Pulse Good vol. **Heart Sounds** I ++ +0.

JVP ⟺

Oedema Nil

Peripheral Pulses Palpable ✓✓ **cap refill** 2sec

Gastrointestinal system

Masses: Nil

Organomegaly: Nil

Bowel sounds: Normal

PR: N/A

Neurological system

GCS: 15/15 **E:** 4/4 **M:** 6/6 **V:** 5/5 **AMT:** 4/4 (AMT 4 = age, time, place, year)

Pupils/fundoscopy:

Cerebellar and extrapyramidal:

Cranial Nerves:

Neck:

	RUL	LUL	RLL	LLL
Tone				
Power				
Co-ordination				
Reflexes				
Sensation				

Gait:

Locomotor

	Tender	Swollen	Deformity	Which joint?
Arms				
Legs				
Spine				

Cycle 20

Investigations

Bloods.
HCG
CXR.

(Differential) diagnosis

? Pancreatitis
~~Gastritis~~? Gastritis / ? GORD.

Management Plan

IV fluids
NBM at present.
Peptac / omeprazole
ETHANOL level.

Thromboprophylaxis assessed ☐ **Medicine Reconciliation** ☐ **DD6 if required** ☐

Signature **PRINT NAME** **PRINT GRADE** Page: 5 of 7

Senior/Medical review

Admission checklist

Investigations reviewed ☐ **Kardex** ☐ **eKIS reviewed** ☐
Thromboprophylaxis assessed ☐ **Medicine Reconciliation** ☐ **DD6 if required** ☐

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

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

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

Pt Addressograph

Surgical patients start here

Non-operative [mainly medical] patients start here

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

Yes ☐ No ☐

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

Age >60	☐	Use of oestrogen-containing contraceptive therapy	☐
Active cancer or cancer treatment	☐	Use of hormone replacement therapy	☐
Dehydration	☐	Pregnancy or < 6 weeks post partum [seek specialist advice]	☐
Known thrombophilias	☐	Critical care admission eg HDU/ITU	☐
Obesity (BMI>30)	☐	Total anaesthetic + surgical time >90 minutes	☐
Current significant medical condition e.g. Serious infection, Heart failure, Respiratory disease or inflammatory disease	☐	Surgery involving pelvis or lower limb with a total anaesthetic + surgical time >60 minutes	☐
Personal history or first degree relative with a history of VTE	☐	Acute surgical admission with inflammatory or intra-abdominal condition	☐
Varicose veins with phlebitis	☐	Hip fracture	☐

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

Yes, 1 or more risk factors identified ☐

No risk factors identified ☐

Does the patient have any contraindications to pharmacological prophylaxis? (tick √ all that apply)

Active bleeding	☐	Untreated inherited bleeding disorders (e.g. haemophilia or von Willebrands)	☐
Acquired bleeding disorders (e.g. acute liver failure)	☐	Neurosurgery, spinal or posterior eye surgery	☐
Concurrent use of anticoagulants (such as warfarin with INR>2)	☐	Lumbar puncture, epidural/spinal anaesthesia expected within the next 12 hours	☐
Acute stroke	☐	Other procedure with high bleeding risk – discuss with senior if unsure	☐
Uncontrolled hypertension (230/120 mmHg or higher)	☐	Lumbar puncture, epidural/spinal analgesia within the previous 4 hours	☐
Thrombocytopenia (<75 x 10^9/l)	☐	Thyroid surgery	☐

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

No contraindications to pharmacological prophylaxis identified ☐

Contraindications to pharmacological prophylaxis identified ☐

Surgical patients – Enoxaparin 40mg + AES ☐*

*prior to application of AES, please check contraindications to AES

Medical patients – Enoxaparin 40mg ☐

Prescribe Enoxaparin at 6pm

[on day of surgery, at the later of either 4h post-op or 6pm]

Reduce Enoxaparin to 20mg if <50Kg or eGFR <30ml/minute/1.73m² ☐

Discontinue at discharge or when returned to pre-morbid mobility

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

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

Risk assessment result – please tick √ all that apply

VTE risk factors: YES ☐ NO ☐ Contraindications to pharmacological prophylaxis: YES ☐ NO ☐ Prescribed: LMWH ☐ AES ☐ NONE ☐

Patient informed of VTE risks and benefits of thromboprophylaxis YES ☐ NO ☐ N/A ☐ Information leaflet provided YES ☐ NO ☐

Print Assessor's Name: _____ Signature: _____ Date: _____

DD6 All patients over 64

4AT	Y/N/Na
Carers involved	Y/N/Na
Med rec	Y/N/Na
Sepsis Screen	Y/N/Na
Resuscitation status considered	Y/N
Discharge planning	Y/N/Na

Sepsis Six

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

Cycle 20

Results

Baseline	Date									
	Time									
	Parameter	Ref Range								
	Hb	130-180	135							
	WCC	4.0-11.0	6.2							
	Plts	150-400	278							
	MCV	78 - 99	86.7							
	Neut	2.0 - 7.5	4.5							
	PT	9.0 - 13.0	11							
	APTT	27.0 - 38.0	31							
	Fibrinogen	1.5-4gm/L								
	INR	( )								
	Thromb T	11-15 secs	15							
	D-Dimer	<230	114							
	ABG/VBG									
	Na^+	135 - 145	140							
	K^+	3.5 - 5.0	3.9							
	Cl^-	97 - 107	107							
	HCO_3^-	23 - 30								
	Urea	2.5 - 7.5	3.1							
	Creat	62 - 124	64							
	eGFR		>60							
	Glucose	3.5 - 5.9	5.5							
	Protein	32 - 82								
	Albumin	37 - 50	39							
	AlkP	33 - 117	80							
	Bil	0.5 - 19	4							
	ALT	11 - 55	44							
	AST	13 - 42	32							
	GGT	8-60								
	ESR									
	CRP	<3	1							
	Troponin I hs	Men 0 - 34 Women 0 - 16								
	CK	23 - 190								
	Corr Ca^{++}	2.25 - 2.60								
	PO_4^-	0.8 - 1.4								
	Mg^{++}	0.7 - 1.1								
	Digoxin	0.5 – 2.0								
	Alcohol									
	Paracetamol	<100 @4 hr								
	Salicylate									
	Amylase	<100	(116)							
	LDH	240 - 480								
	Folate	3.1 - 20								
	B12	200 - 900								
	Ferritin	15 - 200								
	TSH	0.35 – 5.00								
	T4	9 - 21								
	Urinalysis									

DON'T MISS AKI Checklist within 24 hrs of admission

D Dipstick Urine: _____

O Obtain Ultrasound: Yes ☐ N/A ☐

(Stage 2/3: within 24 hours of Admission)

N Need for Catheter: Long-term ☐ Yes ☐ No ☐ Refused ☐

T Team Renal to contact: Considered ☐ Done ☐ N/A ☐

M Medicine Reconciliation: ☐

I Intravenous Fluids: Yes ☐ Contraindicated ☐

S Suspected Cause: _____

S Staging of AKI: (Tick Box Below)

☐ 1 (RISK if: Creatinine X 1.5)
☐ 2 (INJURY if: Creatinine X 2)
☐ 3 (FAILURE if: Creatinine X 3)
(compared to baseline)

Signature/Name/Grade _____

Cycle 20

Post Take Ward Round AMU/MAU/OAAU

Consultant: Clark **Date:** 24/7/17 **Time:** 20^{00}

Summary (28) → Prev. alc XS
Gastritis
Pancreatitis
Pericarditis
Inguinal hernia

Had been on outdoor course in the Highlands
- walking up "really big mountains"

Now has central chest pain
- pleuritic
- no sputum
- feels generally unwell
- muscle aches + nausea

Had bottle of buckfast today
Smokes cigarettes - says no cannabis for 4/52
Says feels like has chest infection

Imp viral LRTI

Plan (H)
advised to take plenty of fluids + simple analgesia

Temp:
Pulse:
BP:
Sat O2:
FiO2:
RR:

ECG: SR **Bloods:**

CXR: nil focal **Other investigations:**

Imp:

Plan:

AWI considered ☐ Thromboprophylaxis need reviewed ☐ Medicine reconciliation complete ☐
If cardiac or respiratory arrest is considered a possibility for the patient has CPR status been reviewed and documented Yes ☐ No ☐
CPR decision discussed with patient Yes ☐ No (document why) ☐ Advanced directive in situ ☐ Treatment escalation plan (circle) Ward/HDU/ITU
Family informed of CPR/escalation status? – Needs discussed at first opportunity ☐ Has been discussed ☐ Patient does not want family informed ☐

Recommended Destination: Home
Suitable to board if required Yes ☐ No ☐
Expected Date of Discharge: 24/7/17

Signature:
Designation: CCS
Bleep Number:

Junior/Senior additional notes, communications with relatives

NOTES

NOTES

1203893450
WEIR M
James 12/03/1989

Patient

ID:	1203893450
Last Name:	**WEIR**
First Name:	**JAMES**
Gender/Age:	Male, 28 years
Birth Date:	12/03/1989
Status:	**ACCEPTED**
Analyzed:	24/07/2017 17:33:48
Drawn:	24/07/2017
Sample Type:	**Venous**
Account Number:	
Order Number:	
Sample Number:	
Clinician:	
Operator ID:	DRAFFTON C

Analyzer

Model:	GEM® *Premier 4000*
Area:	RAHMAU
Name:	RAHMAU
S/N:	08091832

Measured (37.0°C)		
cH	39.4	nmol/L
pCO_2	5.6	kPa
pO_2	5.2	kPa
Na^+	139	mmol/L
K^+	3.6	mmol/L
Cl^-	108	mmol/L
Ca^{++}	1.12	mmol/L
Glu	5.8	mmol/L
Lac	2.0	mmol/L
CO-Oximetry		
tHb	140	g/L
O_2Hb	75.8	%
COHb	4.5	%
MetHb	1.0	%
HHb	18.7	%
Derived		
BE(B)	1.0	mmol/L
HCO_3^-(c)	26.0	mmol/L
Operator Entered		
Temp	37.0	°C

24.

Acute Services Division

Nursing Admission & Assessment

1. Admission

NHS Greater Glasgow and Clyde

Hospital: RAH	Ward: MRU
Date of admission: 24/7/17	Time: 1710
Admitting Consultant: CLARK.	Admitting Nurse: DRAFFAN
Expected date of discharge: / /	

Name: 1203893450
Addres: WEIR James M
27D MACDOWALL STREET 12/03/1989
Johnstone, Renfrewshire
DoB:...
PA5 8QJ
CHI nu
Affix patient data label

1. Patient Details

Preferred name: James.	Next of Kin (NoK): Debbie
Age: 28.	Relationship: Sister
Religion: NA.	NoK Address:
Telephone:	
GP: Dr. JC Sim, Quarryside Practice, Linden Medical Centre	NoK Telephone: 07588519964
GP address: 25 Floors Street, Johnstone, PA5 8PZ	NoK Aware of admission: ☐ Yes ☐ No
	Consent for information to be given to relative/carer/friend: ☑ Yes ☐ No
	Nominated relative/carer/friend contact:
GP telephone:	Telephone - Day: Telephone - Evening:

Is the patient a carer? ☐ Yes ☑ No If 'Yes' refer to Duty Social Worker if required: ☐ Referred ☑ Not required

Does the patient have an appointed Welfare Guardian / Power of Attorney? ☐ Yes ☐ No ☑ N/A

a. If 'Yes' please provide – Name: ..... Relationship: .....
Contact telephone number: .....

b. If 'Yes' does the patient have an 'Adult with Incapacity Section 47' certificate in place? ☐ Yes ☑ No
If 'Yes' obtain a copy and file with patient notes.
If 'No' to 'b' please inform medical staff. Name of doctor informed: .....

2. Presenting Complaint / Diagnosis

Have treatment / investigations:

Central chest pain

Why does the patient think they are in hospital? *Use patients own words:*

3. Allergies (including food allergies)

No known allergies: ☑

4. Observations

Cannard	Waterlow	MUST	Pulse	BP	Resp	SaO_2	Temp
✓	RURA 4°	NA	113	117/65	18	96% (A)	37.4

Urinalysis:	BM	NEWS Score	Weight Patient reported for weight /Actual	Height Patients reported height / Actual	BMI
Negative	5.8	2			

5. Current Medication

6. Relevant Past Medical History

Prev. drug & alcohol abuse.
Gastritis
Pancreatitis
Pericarditis
Ingnal hernia

7. Risk Assessment

MUST Screening Tool

1. Is the patient's BMI:
   - > 20 .....Score 0
   - 18.5-20 .....Score 1
   - <18.5 .....Score 2
   - Score ☐
2. Has the patient had unplanned weight loss in the past 3-6 months?
   - < 5%.....Score 0
   - 5-10%.....Score 1
   - >10%.....Score 2
   - Score ☐
3. If the patient is acutely unwell and there has been or is likely to be no food intake for > 5 days:
   - Score = 2
   - Not applicable: Score = 0
   - Score ☐

MUST Score: ☐

If score 1 or more, complete full Nutrition Profile

Swallow Risk Assessment

Has the patient had, or is suspected of having, a stroke, a TIA or is suspected of having a swallowing difficulty? ☐ Yes ☐ No

If YES complete a STOPSS screening tool.

STOPSS completed ☐ Yes ☐ No

N 1203893450 M.....

Ac WEIR James 12/03/1989

27D MACDOWALL STREET

Johnstone, Renfrewshire PA5 8QJ

Dc .....

Ch .....

Affix patient data label

8. Cognitive Impairment / Delirium

Think Delirium

Do 4AT on all patients over 65 yrs

and

on patients of any age with one or more of the following:

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

9. MRSA Screening / CJD / Healthcare outside Scotland

Will the patient be an inpatient >23 hours? ☐ Yes ☑ No If 'Yes' complete the following section.

1. Has the patient ever had a previous positive MRSA result? ☐ Yes ☑ No ☐ Not known
2. Has the patient been admitted from a Care Home/ institutional setting or another hospital? ☐ Yes ☑ No ☐ Not known
3. Does the patient have a wound / ulcer or invasive device which was present prior to this admission? ☐ Yes ☑ No ☐ Not known

If **'Yes'** to any of the above questions **OR** if the patient is admitted to a 'high impact speciality' e.g. **Orthopaedics, Vascular, Renal Unit, Critical Care – then obtain MRSA Swabs:**

☐ **Nasal** ☐ **Perineum** ☐ **Other - Specify:** ☐ **Patient refused**

CJD: **Has the patient ever been contacted by Public Health and told that they are possibly at risk of CJD:**

☐ Yes ☑ No If 'Yes' contact Infection Control Team. Infection Control Team contacted: ☐

Healthcare outside Scotland

Has the patient been transferred from, or received health care in, a hospital outside of Scotland in the last 12 months:

☐ Yes ☑ No If 'Yes obtain rectal swab and send to microbiology for CPE screen.

Rectal swab taken ☐ Patient refused ☐

10. Lifestyle

Smoking:

Are you a smoker ☑ ex-smoker ☐ never smoked ☐

If ex-smoker when did they stop? .....

If smoker how many cigarettes per day 10-30 day.

If smoker, or recent ex-smoker, would they like to use nicotine replacement therapy to prevent withdrawal discomfort while in hospital? ☐ Yes ☐ No

If smoker, would they like to stop now with the support from stop smoking service? ☐ Yes ☐ No

If Yes refer to Smoking Cessation Service

Drugs: Does the patient use recreational drugs? ☐ Yes ☑ No If 'Yes' specify:

Alcohol (Men): How often do you have **8** or more drinks on one occasion:

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

If 'Monthly' or more then complete FAST Tool.

Alcohol (Women): How often do you have **6** or more drinks on one occasion:

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

If 'Monthly' or more then complete FAST Tool.

11. Admission Documentation Completed By

Name (Please PRINT): C. DRAFFAN	Signature:
Designation: SN	Date: 24/7/17

Acute Services Division

Nursing Admission & Assessment

2. Assessment

Hospital: RAH	Ward: MAU.
Date of Assessment: 24/7/17	Time: 1710.



1203893450

Na WEIR M
Ad James 12/03/1989
27D MACDOWALL STREET
Johnstone, Renfrewshire
Dc PA5 8QJ
Cl

Affix patient label here.

1. Breathing and Circulation

Breathing:

- ☐ No symptoms or history of respiratory problems
- ☐ Dyspnoeic at rest
- ☐ Dyspnoeic on minimal exertion
- ☑ Dyspnoeic on maximum exertion
- ☐ Productive / non-productive cough evident
- ☐ Normally receives oxygen therapy

If 'Yes' provide details:

Circulation:

- ☑ No symptoms
- ☐ known high blood pressure ☐ known angina ☐ current chest pain

Problem identified: ☐ Yes ☐ No If 'Yes' please describe

Initial CO

2. Communication

Assessment of ability to communicate:

What language does the patient speak?:

English.

Interpreter: Required ☐ Not required ☑

If required, provide details and arrangement made:

Does the patient have:

a. Speech difficulties? ☐ Yes ☑ No

b. A learning disability e.g. Down's Syndrome?

☐ Yes ☑ No

If 'Yes' please specify:

If 'Yes' contact Liaison Learning Disability Team.

Liaison Learning Disability Team contacted:

☐ Yes ☑ No

c. A learning difficulty e.g. dyslexia, dyspraxia?

☐ Yes ☑ No

If 'Yes' please specify:

3. Senses

Senses:

Eyesight

- ☑ Normal vision
- ☐ Glasses – ☐ Distance ☐ Reading
- ☐ Prosthesis – ☐ Left ☐ Right
- ☐ Contact lenses
- ☐ Registered blind

Hearing

- ☑ Normal
- ☐ Hearing impaired
- ☐ Hearing aid – ☐ Left ☐ Right

4. Cognitive Status

Cognitive Status:

- ☑ Orientated
- ☐ Confused
- ☐ Distressed
- ☐ Aggressive /Abusive
- ☐ Known dementia
- ☐ Unconcious

Problem identified: ☐ Yes ☐ No If 'Yes' please describe

Initial CO

5. Hydration and Nutrition

Nat 1203893450 .....
Adr WEIR .....
James M
.... 27D MACDOWALL STREET 12/03/1989.....
Dc Johnstone, Renfrewshire .....
Cl PA5 8QJ .....

MUST Score: ..... **If score is 1 or more, complete a Nutrition Profile.**

Nutrition Profile completed ☐ Yes ☐ No
If 'Yes' do not complete sections 5a to 5d.

- **If score is 0, reassess / screen patient in 7 days.**
- **Complete sections 5a to 5d.**

Date of reassessment: / /

5a 1. Food likes / dislikes:

No preference

5a 2. Fluid likes / dislikes:

5c. Help needed with eating and drinking:
☐ Yes ☒ No
If 'Yes' provide details:

5b. Cultural or religious diet needed (e.g. vegetarian, vegan, halal, kosher etc):
☐ Yes ☒ No
If 'Yes' specify diet needed:

5d. Texture Modified Diet needed?
☐ Yes ☒ No
If 'Yes' specify texture: A☐ B☐ C☐ D☐ E☐
Thickened Fluids required? ☐ Yes ☐ No
If 'Yes' specify stage required: 1☐ 2☐ 3☐

Problem identified: ☐ Yes ☐ No If 'Yes' please describe

Initial AP

6. Elimination

Continent:
☒ Bladder
☒ Bowel

Incontinent:
☐ Bladder
☐ Bowel

NHS GGC Stool Chart commenced:
☐ Required ☒ Not required

Long-term urinary catheter in situ? ☐ Yes ☒ No If 'Yes' – Size: ..... fg Make:.....
If Yes is it urethral ☐ suprapubic ☐ Date catheter last changed: / /

Continence assessment commenced:
☐ Yes ☐ No ☒ Not applicable

Containment products in use? Please specify:

☒ Bowels regular
☐ Constipated
☐ Diarrhoea / loose stools

Stoma: ☐ Yes ☒ No
If 'Yes' please specify and list appliances used:

Problem identified: ☐ Yes ☐ No If 'Yes' please describe

Initial AP

7. Personal Hygiene, Oral Health and Skin Assessment

Nan 1203893450 M
Addi WEIR 12/03/1989
..... James
DoB: 27D MACDOWALL STREET
Johnstone, Renfrewshire PA5 8QJ
CHI n
... data label

Personal hygiene:

☑ Self-caring and independent
☐ Requires assistance

Specify assistance if required:

Oral health:

Self-caring and independent	☑ Yes	☐ No
Does the patient have a sore mouth	☐ Yes	☑ No
Does the patient have a non healing mouth ulcer	☐ Yes	☑ No

If the patient has a sore mouth or non healing mouth ulcer, refer to dentist (See StaffNet for dentist referral pathway).

Dentures:

Does the patient wear a denture plate?
☐ Yes ☑ No

If yes complete the following:
☐ Full set ☐ Upper set ☐ Lower set
☐ Dentures with patient on admission

Skin assessment:

☑ Skin healthy with no evidence of damage
☐ Skin broken ☐ Skin oedematous ☐ Skin discoloured ☐ Skin clammy
If 'Yes' to any of the above, describe skin condition:

Wound Assessment Chart completed: ☐ Yes ☐ No ☐ Not applicable
Pressure ulcer evident: ☐ Yes ☐ No
If 'Yes' please identify Grade and record on Pressure Ulcer record sheet – Grade: .....

Problem identified: ☐ Yes ☐ No If 'Yes' please describe

Initial

8. Mobility

Patient fully mobile / independent? ☑ Yes ☐ No If 'No' complete Moving and Handling Assessment.

☐ Limited mobility
☐ Mobile with aid – Specify:
☐ Prosthesis – Specify:

Moving and Handling Plan commenced:
☐ Yes ☑ No

Problem identified: ☐ Yes ☐ No If 'Yes' please describe

Initial

9. Maintaining a Safe Environment

Pain status:

Does the patient have pain? ☑ Yes ☐ No
If 'Yes' record Pain Score on NEWS chart.

What makes their pain better? Please provide brief details:

Bed rail assessment completed: ☐ Yes ☑ No

Bed rails required:
☐ Required ☑ Not required

Problem identified: ☐ Yes ☐ No If 'Yes' please describe

Initial

0. Sleep and Rest

Sleep habits:

☐ Less than 8 hours ☐ Afternoon nap
☐ Morning nap

Sleep difficulties:

☐ None ☐ Disturbed
☐ Early wakening e.g. nocturia, insomnia

Medication required: ☐ Yes ☐ No

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A WEIR M
.. James 12/03/1989
27D MACDOWALL STREET
D Johnstone, Renfrewshire
PA5 8QJ
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Affix patient data label

Problem identified: ☐ Yes ☐ No If 'Yes' please describe

Initial

1. Social Circumstances

☑ Employed ☐ Unemployed ☐ Retired
☐ Health problems at work
☑ Lives alone
☐ Lives with Family
☐ Friend
☐ Dependants
☐ Other: ☐ Nursing Home ☐ Residential

Current Care / Support arrangements:

☐ Social Services

Unpaid carer ☐ Yes ☐ No
If Yes are they Partner / Friend / Son / Daughter
What kind of care do they provide?:

☐ Private Carers
☐ None

If support services in place, please provide details:

No Services.
- Cleaner

Does the patient have any money worries? ☐ Yes ☑ No
If Yes would the patient like to be referred to a money advice service that can offer confidential advice / support?
☐ Yes ☑ No
If Yes please identify date patient referred: ...../...../.....
Would the patient like a referral to a service that can support them with employment / education/training/skills /volunteering
☐ Yes ☑ No
If Yes please identify date patient referred: ...../...../.....

Problem identified: ☐ Yes ☐ No If 'Yes' please describe

Initial

12. Privacy, Dignity and Sexuality

Does the patient have issues related to privacy, dignity and/or sexuality that are relevant to admission?
☐ Yes ☑ No

If 'Yes' please provide brief details:

13. Spiritual Care

Is there anything with regard to faith or culture that we can support the patient with during their stay in hospital (e.g. prayer, meditation)?
☐ Yes ☑ No

If 'Yes' please provide brief details:

Is there anything causing the patient a lot of anxiety at the time of admission that staff should be aware of?
☐ Yes ☑ No

If 'Yes' please provide brief details:

Ask the patient:
"Would you like the ward staff to arrange for a Hospital Chaplain to visit you while in hospital?"
☐ Yes ☐ No ☑ Not at this time

If 'Yes' please specify faith group:

14. Anticipatory Care

(This section is for patients thought to be in the last year of life, where appropriate and relevant)

Appropriate ☐ Not appropriate ☑

Nam 1203893450 .....
Add WEIR .....
James M
..... 27D MACDOWALL STREET 12/03/1989.....
Dol Johnstone, Renfrewshire .....
CH PA5 8QJ .....
Affix patient ...

Is the **patient** aware of their:
Diagnosis? ☐ Yes ☐ No
Prognosis? ☐ Yes ☐ No

Is the **patient's family** aware of their:
Diagnosis? ☐ Yes ☐ No
Prognosis? ☐ Yes ☐ No

Preferred place of care:
Home: ☐ Hospital ☐ Hospice ☐

Preferred place of death:
Home: ☐ Hospital ☐ Hospice ☐

Current treatment – please identify (e.g. chemotherapy/ radiotherapy):

Other agencies involved in patient's care – please identify (e.g.) Marie Curie, MacMillan Nurses):

DNACPR order in place: ☐ Yes ☑ No
If 'Yes' are the patient's family and next of kin aware? ☐ Yes ☐ No

15. Admission Assessment Completed By

Name (Please PRINT): C DRAFFAN

Signature:

Designation: SN

Date: 24/7/17

Clinical Notes

Date and Time	Notes	Name, Signature and Designation
24/7/17 1730	Patient refered via GP with central chest pain 5-6 days ago when doing the West highland way. Patient states pain worsening when climbing a hill and struggling to breath when ~~pat~~ pain promedient.	

Clinical Notes continue on next page

Nam 1203893450
Addr WEIR
James M
27D MACDOWALL STREET 12/03/1989
DoB Johnstone, Renfrewshire
CHI PA5 8QJ

Clinical Notes (continued)

Date and Time	Notes	Name, Signature and Designation
Imp:	?ACS ?LRTI.	
Plan	· Bloods	✓
	↳ inc. Troponin, Amylase	✓
	· Blood cultures.	✓
	· VBG.	✓
	· IV Fluids.	✓
	· Urinalysis - NAD.	✓
	NEWS (2) HR 113 bpm.	
	Patient out celebrating completing	
	the West Highland way and had	
	'couple' drinks of buckfast	
	↳ previous drug and alcohol abuse - denies drug use.	SJ CORAFFAN
18^{20}	NEWS now (1) HR 108 bpm.	
	Troponin 1 CRP < 1 WCC (N).	SJ CORAFFAN
	U+Es - (N). Amylase 116.	

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☐ NURSING ☑

Please tick ✔ appropriate directorate

1203893450
WEIR M
James, 12/03/1989
27D MACDOWALL STREET
Johnstone, Renfrewshire
PA5 8QJ

Date & Time	24/7/A	Signature, Print Name & Designation
20⁰⁰	S/B Dr Clarke	
Imp:	Viral Chest Infection	
Plan	Home advised with plenty of fluids and simple analgesia.	
	Venflon removed.	

83949 GGC0072

Date & Time		Signature, Print Name & Designation

NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

Name
Address
1203893450
WEIR M
James 12/03/1989
27D MACDOWALL STREET
Johnstone, Renfrewshire
CHI No. PA5 8Q
DoB

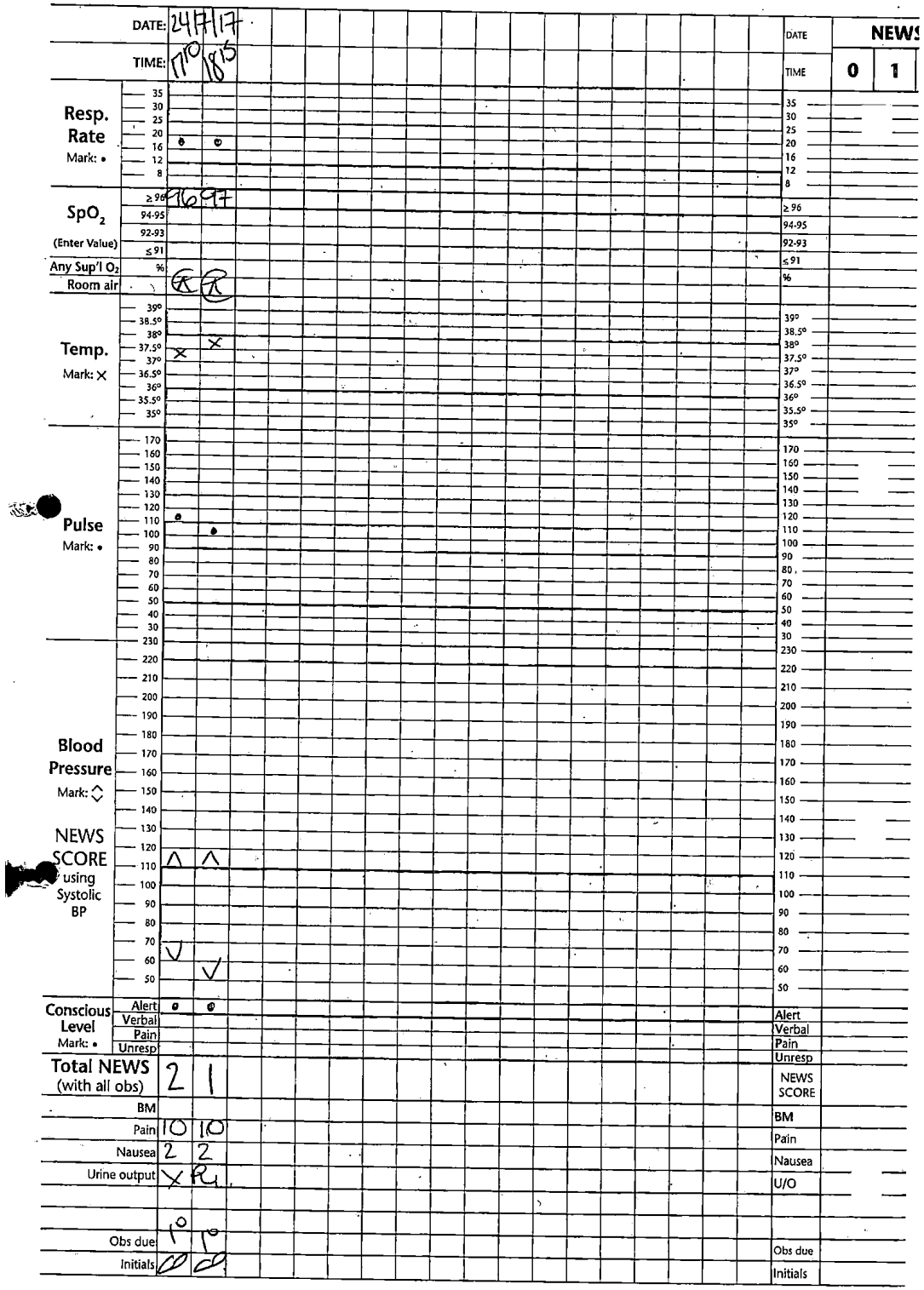
	Date	Ward
Admitted	24/7/17	MAU
Transferred		
Transferred		

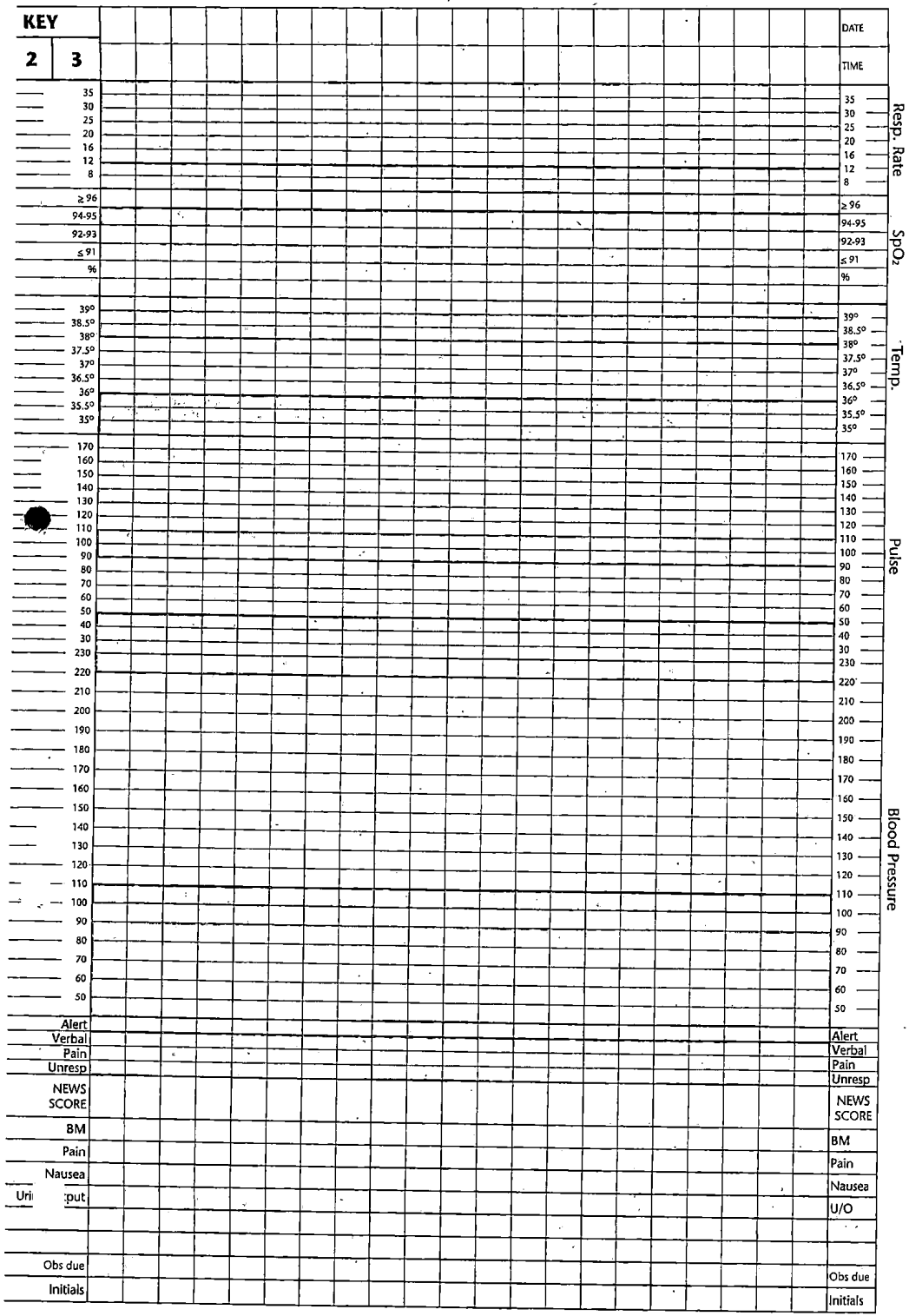
Physiological Parameter	NEWS – NHS Early Warning Score						
	3	2	1	0	1	2	3
Respiration Rate	≤8		9-11	12-20		21-24	≥25
Oxygen Saturations	≤91	92-93	94-95	≥96			
Any Supplemental Oxygen		Yes		No			
Temperature	≤35.0°		35.1-36.0°	36.1-38.0°	38.1-39°	≥39.1°	
Pulse	≤40		41-50	51-90	91-110	111-130	≥131
Systolic BP	≤90	91-100	101-110	111-219			≥220
Conscious Level				A			V, P or U

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

See NEWS Actions Reference Tool for local escalation policy

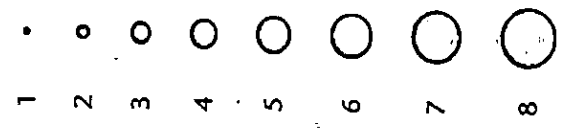
NEWS Score	Frequency of Monitoring	Clinical Response
0	Minimum 12 hourly	• Continue routine NEWS monitoring with every set of observations.
Aggregate 1- 4	Minimum 4 hourly	• Inform trained nurse. • Trained Nurse assessment: - Assess the patient - Review frequency of monitoring required - Assess need for escalation of clinical care and direct as appropriate.
Aggregate 5 or more **or** 3 in one parameter	Increased frequency to a minimum of 1 hourly	• Trained Nurse assessment. • Inform medical team caring for the patient. • Urgent assessment by a medical / surgical / nursing team with core competencies to assess acutely ill patients. • Consider level of monitoring required in relation to clinical care.
Aggregate 7 or more	Continuous monitoring of vital signs	• Trained Nurse to assess immediately. • Inform medical team caring for the patient – this should be at least senior medical staff level. • Emergency assessment by a clinical team with core competencies in the assessment of critically ill patients. This team will have critical care competencies and a practitioner/s with advanced airway skills and resuscitation skills. • Consider referral to high dependency or ITU.


DATE: 24/7/17
TIME: 1710 1815
Resp. Rate
Mark: •
SpO2
(Enter Value)
Any Sup'l O2
Room air
96 97
Temp.
Mark: ×
Pulse
Mark: •
Blood Pressure
Mark: ◇
NEWS SCORE using Systolic BP
Conscious Level
Mark: •
Alert
Verbal
Pain
Unresp
Total NEWS (with all obs) 2 1
BM
Pain 10 10
Nausea 2 2
Urine output
Obs due
Initials
DATE
TIME
NEWS
0 1
NEWS SCORE
BM
Pain
Nausea
U/O
Obs due
Initials


KEY
2
3
DATE
TIME
Resp. Rate
35
30
25
20
16
12
8
SpO2
≥ 96
94-95
92-93
≤ 91
%
Temp.
39°
38.5°
38°
37.5°
37°
36.5°
36°
35.5°
35°
Pulse
170
160
150
140
130
120
110
100
90
80
70
60
50
40
30
Blood Pressure
230
220
210
200
190
180
170
160
150
140
130
120
110
100
90
80
70
60
50
Alert
Verbal
Pain
Unresp
NEWS SCORE
BM
Pain
Nausea
U/O
Obs due
Initials

Glasgow Coma Scale

Pupil size (mm)



Neurological Observations

| | | |

Pressure Ulcer Daily Risk Assessment (PUDRA)

NHS Greater Glasgow and Clyde

1203893450 WEIR M James 12/03/1989 27D MACDOWALL STREET Johnstone, Renfrewshire PA5 8QJ	Hospital: RAH Ward: MAU.	**Points to consider:** • Use within 6 hrs of admission to care area • Re-assess daily and more frequently if a person's condition changes

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

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

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

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

If NO to all statements, continue Active Care Prescribing as assessed for individual need and re-assess daily.

Date	Time	Pressure Damage	Mobility	Continence	Nutrition	Skin Compromised	Clinical Judgement	Active Care Prescribed	Signature
24/7/18	18:00	NO	NO	NO	NO	NO	NO	4hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
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/ /	:							___hrly	
/ /	:							___hrly	

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

Prevention of Pressure Ulcer Intervention Plan

NHS Greater Glasgow and Clyde

Attach Addressograph

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

Outcome: To prevent pressure ulcer development through establishment of effecting work practices in line with SSKINS bundle.

	S SKIN INSPECTION	S SURFACE	K KEEP MOVING	I INCONTINENCE / MOISTURE	N NUTRITION	S SELF MANAGEMENT / SHARED CARE	Sign / Comments
Date of initial plan:	Check: • Pressure areas _____ hourly. • Skin under medical devices _____ hourly. • Specify medical devices used:	Specify: • Mattress: • Cushion: • Detail additional pressure redistributing equipment:	• Reposition _____ hourly in bed and chair. • Overnight patient / carer has agreed to repositioning _____ hourly • Specify any manual handling equipment used:	• Skin care to be carried out _____ hourly. • Specify products required for increased moisture / continence management:	• Optimise nutrition and hydration. • Refer to MUST	• Discuss and agree plan with patient / family/ carer YES ☐ NO ☐ • "Prevent Pressure Ulcers" leaflet given to patient / family / carer? YES ☐ NO ☐	Date discontinued: _____
Date Reviewed:	Check: • Pressure areas _____ hourly. • Skin under medical devices _____ hourly. • Specify medical devices used:	Specify: • Mattress: • Cushion: • Detail additional pressure redistributing equipment:	• Reposition _____ hourly in bed and chair. • Overnight patient / carer has agreed to repositioning _____ hourly • Specify any manual handling equipment used:	• Skin care to be carried out _____ hourly. • Specify products required for increased moisture / continence management:	• Optimise nutrition and hydration. • Refer to MUST	• Discuss and agree updated plan with patient / family/ carer YES ☐ NO ☐	Date discontinued: _____
Date Reviewed:	Check: • Pressure areas _____ hourly. • Skin under medical devices _____ hourly. • Specify medical devices used:	Specify: • Mattress: • Cushion: • Detail additional pressure redistributing equipment:	• Reposition _____ hourly in bed and chair. • Overnight patient / carer has agreed to repositioning _____ hourly • Specify any manual handling equipment used:	• Skin care to be carried out _____ hourly. • Specify products required for increased moisture / continence management:	• Optimise nutrition and hydration. • Refer to MUST	• Discuss and agree updated plan with patient / family/ carer YES ☐ NO ☐	Date discontinued: _____

231550 GGC0207

mi ● 282957

Writ
Nan 1203893450
Add WEIR M
James 12/03/1989
27D MACDOWALL STREET
CHI Johnstone, Renfrewshire
DOI PA5 8QJ
Hos

Peripheral Vascular Cannula (PVC) Insertion & Maintenance

NHS Greater Glasgow and Clyde

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

Insertion – Tick appropriate answer					
Clinical indication:	**Diagnostics** ☐	**Resuscitation / Chest Pain** ☑	**IV Drugs** ☐	**Fluids** ☐	**Transfusion** ☐
PVC inserted:	**Date:** 24/7/17 **Hospital:** RAH		**ED** ☐ **Theatre** ☐ **ITU/HDU** ☐		**Ward** ☑ MAU
Insertion site:	**L Arm** ☐ **R Arm** ☑	**L Hand** ☐ **R Hand** ☐	**L Foot** ☐ **R Foot** ☐	**Other**	
Colour of cannula:	**Blue** ☐ **Pink** ☑	**Green** ☐ **White** ☐	**Grey** ☐ **Orange** ☐		

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

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

Date & time	Comments	Signature

IVOS – consider changing from IV to oral

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

Peripheral Vascular Cannula (PVC) Insertion & Maintenance

NHS Greater Glasgow and Clyde

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

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

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

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

Date & time	Comments	Signature

"/OS – consider changing from IV to or-"

NHS Greater Glasgow and Clyde
Active Care Checklist

Date: 24/7/17

Attach Addre
1203893450
WEIR M
James 12/03/1989
27D MACDOWALL STREET
Johnstone, Renfrewshire
PA5 8Q

Ward: MMU

NHS Greater Glasgow and Clyde

I have evaulated and deemed that the frequency of care delivery over the next work shift, based on the patients' most critical need should be every (please circle) 1hr 2hr 3hr 4hr (6hr)

1. Signed [redacted] Name: C DRAFFAN Designation SN
2. Signed ..... Name: ..... Designation .....
3. Signed ..... Name: ..... Designation .....

Individual patient needs: Red mat required: Y / N Bed Rails: Y / N
'Must do's' for me. Ask the patient if there is anything they want specifically done today:
.....

USE FOLLOWING CODE:

O = Off the ward V = Variant S = Sleeping I = Independent NT = No Thanks

			Times	17 30																			
	1	**Pain: assess and address** If in pain inform registered nurse **Y / N or N/A**		Y																			
S	2	**SKIN INSPECTION** Pressure areas checked: **Y / N or I** (Independent)		I																			
		Redness (**R**) / Discolouration (**D**) / Pressure Ulcer (**PU**) / Intact (**INT**)																					
K	3	**KEEP MOVING:** Have you moved or walked **Y / N or I** (Independent)		I																			
		Bed Right side (30° tilt) – **R** Left side (30° tilt) – **L** Back – **B**																					
		Chiar Assist to walk, stand or tilt (**W /ST/ T**)																					
I	4	**ELIMINATION:** Do you need the toilet? **I** = Independent **A** = Assistance given **IC** = patient incontinent of urine or faeces		I																			
N	5	**FOOD, FLUIDS AND NUTRITION:** Is the patient nil by mouth? **Y / N** (consider mouth care)		N																			
		Encourage the patient to drink? **Y / N / N/A**		Y																			
		Food, snack or supplement taken **Y / N / N/A**		Y																			
	6	**ENVIRONMENT: Check:** Is the patients' call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position? **Y/N/O/S**		Y																			
	7	**INFORMATION: Ask:** Is there anything else I can help you with? Inform patient of the time of return **Y/N/O/S**		Y																			
	8	**ESCALATION:** Escalate any issues to the Registered Nurse **Y / N/A**		NA																			
			Nurse Initials	CD																			

Attach Addressograph Label Ward:

NHS
Greater Glasgow and Clyde

Specialist Pressure Redistributing equipment ordered and in place:

Dynamic Mattress:	
Cushion:	
Orthotic footwear:	
Moving & Handling aids:	
Other:	

Active Care variant sheet – Care Number

1. Pain
2. A/B Skin Inspection
3. A/B/C Keep Moving
4. Elimination
5. Food, Fluid, Nutrition
6. Environment
7. Information
8. Escalation

Date	Time	Number	Variation	Signed

MEDICINE **PRESCRIPTION FORM** Hospital Name: .....

MEDICINES RECONCILIATION

Medicines Reconciled on Admission YES ☐

Date _____ Name (Print) _____

Discharge Prescription Prepared & Reconciled YES ☐

Date _____ Name (Print) _____

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

DOCTOR'S DECLARATION (if required by Local Protocol)

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

with the following exceptions: _____

Print & Sign: _____ Date: _____

COMMUNITY PHARMACY INFORMATION

Name _____ Tel No. _____

Address _____

Compliance Aid Details _____

Patient consent to share discharge information Y/N

Print & Sign _____

PATIENT DETAILS

Hospital Number:	Height:
DOB:	Weight:
Date of Admission: __/__/__	Surface area:
Consultant Name:	Ward:

ONCE ONLY AND PREMEDICATION DRUGS

DATE	DRUG	DOSE	ROUTE	TIME (24hr)	PRESCRIBER (PRINT & SIGN)	GIVEN BY	TIME GIVEN (24hr)
24/7	Keptac	20mg	O		[signature]	[signature]	1900
24/7	Omeprazole	20mg	O		[signature]	[signature]	1900

DATE
MONTH

IS DRUG THROMBOPROPHYLAXIS INDICATED? Y / N

ARE ANTIEMBOLISM STOCKINGS INDICATED? Y / N

SIGNATURE OF ASSESSOR

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

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

Parenteral Drugs : Regular Prescription

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

A DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

B DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

C DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

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

Parenteral Drugs: Regular Prescription

DATE →
MONTH →

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

D DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

---

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

E DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

---

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

F DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

---

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

G DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

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

H

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DRUG: MIRTAZAPINE.

DOSE: 45MG | ROUTE: O | DATE: 24/7/17 | STOPPED DATE: | STOPPED INITIALS:

PRESCRIBER (PRINT & SIGN): [signature] Pharmacy

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

J

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

K

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

L

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

M DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

N DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

P DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

R DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

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

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

S DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

T DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

V DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

W DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

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

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

X DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

Y DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

AA DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

BB DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

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

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

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

CC DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

DD DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

EE DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

FF DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

GG DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

HH DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

JJ DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

KK DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

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

All Routes: As Required Prescriptions

| | | |

BEFORE ADMISSION ☐	RR	DRUG	STOPPED DATE: INITIALS:	DATE		Patient's Own Medicine For Use Y/N
NEW DOSE ☐	DOSE	ROUTE / INDICATION		TIME		Qty:
	PRESCRIBER (PRINT & SIGN)	MAX.FREQ.	DATE:	DOSE		Date:
NEW MEDICATION ☐	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			GIVEN BY		Assessed by: / Ordered from Pharm.
BEFORE ADMISSION ☐	SS	DRUG	STOPPED DATE: INITIALS:	DATE		For Use Y/N
NEW DOSE ☐	DOSE	ROUTE / INDICATION		TIME		Qty:
	PRESCRIBER (PRINT & SIGN)	MAX.FREQ.	DATE:	DOSE		Date:
NEW MEDICATION ☐	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			GIVEN BY		Assessed by: / Ordered from Pharm.
BEFORE ADMISSION ☐	TT	DRUG	STOPPED DATE: INITIALS:	DATE		For Use Y/N
NEW DOSE ☐	DOSE	ROUTE / INDICATION		TIME		Qty:
	PRESCRIBER (PRINT & SIGN)	MAX.FREQ.	DATE:	DOSE		Date:
NEW MEDICATION ☐	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			GIVEN BY		Assessed by: / Ordered from Pharm.
BEFORE ADMISSION ☐	VV	DRUG	STOPPED DATE: INITIALS:	DATE		For Use Y/N
NEW DOSE ☐	DOSE	ROUTE / INDICATION		TIME		Qty:
	PRESCRIBER (PRINT & SIGN)	MAX.FREQ.	DATE:	DOSE		Date:
NEW MEDICATION ☐	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			GIVEN BY		Assessed by: / Ordered from Pharm.

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

Name 1203893450
WEIR M
James 12/03/1989

CHI No
270 MACDOWALL STREET

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

PA5 8QJ

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

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

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

Notes for Users

FOR PRESCRIBERS:

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

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

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

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

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

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

7. The following metric unit abbreviations must be used –

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

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

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

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

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

FOR NURSES

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

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

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

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

Codes for Non-Administration of Drugs

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

Cat. No. 40995 Ver 4, 09/2010 GGC0029

Date	CLINICAL NOTES
	Seen by (Dr) WOLFE (DUTY PSYCHIATRY SHO) Time seen 1745

22/06/17

CT3 - WOLFE

1203893450 12/03/1989
WEIR
James

Thank you for referral

(28) ? Phoned duty hub at Charleston Centre as felt he needed help with his mental health. Was hostile on the phone :- police were called and brought him to A+E.

Known to Dr Kaur at West Renfrewshire CMHT - CPN currently off sick. Diagnosis of emotionally unstable personality disorder and PTSD.

Patient upset - states no one has been helping - Multiple stressors - sexual abuser released from prison and staying in his local area - End of long term relationship a few months ago - Recent argument with his sister - States he has been sober for past 2 weeks - C/O poor sleep recently - Feels medication not working -

O/E - Appears upset and angry - Good rapport - Good eye-contact
- Mood subjectively low - Objectively angry but reactive
- No formal thought disorder - Speech fluent in rate + volume and slightly tangential.
- Thoughts of having been abandoned by services - No suicidal ideation - Wants to engage with services -
- No perceptual abnormalities AVO

Date	CLINICAL NOTES
22/06/17 continued	- Orientated T, P, P - Some insight into problems with a tendency to external locus of control. Impression - social crisis Plan - Referred to RAMH First Crisis for daily support - Diazepam 5mg nocte prescribed for 3 nights to help with sleep. - I will communicate with Dr Kaur's team tomorrow to request urgent appointment. CT3 PSYCHIATRY

Discharge Codes (Please CIRCLE)					Discharge date	
1. Admission	2. Discharge	3. Refer to GP	4. Transfer to other (see below)			
5. Died	6. Refer to OP Clinic (see below)		7. Irregular Discharge	8. D.O.A.	Discharge time	

Ward number (if admitted):	Transfer to hospital:	Consultant If admitted):

Follow up	Arranged	Not arranged	To be arranged

Clinic referred to	A&E	Hand injury	Fracture	Pop Check	Medical	Surgical	ENT	Others (specify):

Discharge Prescription Packs

Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Frequency	Signature	Given By
22/06/17	DIAZEPAM	5mg	ORAL	NOCTE		
	Please supply 3 (three) tablets of 5mg each.					

ADULT EMERGENCY ASSESSMENT
DYKEBAR HOSPITAL

MENTAL STATE EXAMINATION
APPEARANCE & BEHAVIOUR:
New Nike jacket, kempt, well presented, wearing up to date rangers top.
MOOD & AFFECT (Objective & Subjective):
Subjectively – "alright, just feel like an idiot". Objectively – Affect reactive, frustrated with his behaviours yesterday – "drinking binge".
SPEECH & THOUGHT FORM:
Normal rate, rhythm and tone.
THOUGHT / CONTENT
Wants help with alcohol. Wants to deal with childhood sexual abuse. Agrees to consider this with CPN.
PERCEPTUAL ABNORMALITIES:
Nil – denies any.
COGNITION:
Orientated, no obvious issues.
INSIGHT:
Poor.
INFORMATION GAINED FROM OTHER SOURCES (collaborative information):
Social Work on referral. Dishcarge letter from Stuart Gibson.
CLIENTS EXPECTATION OF REFERRAL/SERVICE (recovery focused):
Not sure, just wants help. Wants to get help with alcohol.
CARER'S EXPRESSED NEEDS and EXPECTATIONS OF REFERRAL/SERVICE:
Attempted to call sister Debbie – no answer.

ADULT EMERGENCY ASSESSMENT
DYKEBAR HOSPITAL

SUMMARY (including impression, identified strengths and risks):
28 year old male with diagnosis of EUPD. Referred today secondary to Social Work appointment where he attended for crisis loan. Was refused so said he was suicidal. Had no money as he spent money on drinking binge yesterday. Feels made a "clown" of himself.
RELEVANT STRESSORS:
Lack of finances. Guilt regarding his drink binge yesterday.
PROTECTIVE FACTORS:
Wants help. Wants to get "off the drink".
PLAN:
? CPN to arrange medical review. Contact CPN – Mary McKenzie tomorrow. Appointment to be made to Torley Unit – agreed to this. Will attend Charleston Centre for a food voucher.
DISCUSSED WITH: Dr L Wilson, On Call Spr
Assessors signatures:
PRINT& DESIGNATION

1: Kenny Dock Senior IHTT Practitioner	
2: Paul Philips Senior IHTT Practitioner	

PREVIOUS MENTAL ILLNESS EPISODES (including history of engagement, dates of hospital admissions, detentions, past medications, history of risk eg. Suicide attempts/DSH):

History of deliberate self harm – cutting arms and chest with Stanley knife. Has scarring.
Attempted to set self of fire 2 years ago.
Attempted to hang self 18 months ago.
Reports numerous attendance at Dykebar in the past.
Sertraline prescribed by GP "for years".

One week admission to South Ward (September 2016)
Claimed to be suicidal today.

CURRENT HEALTH ISSUES/MEDICAL HISTORY (including any disabilities, smoking status, investigations)

Nil.

MEDICINES RECONCILIATION

Source (please tick all used)

Patient	Relative/ Carer	Patient order slip	GP ref letter/ print out	GP ECS	GP phone call	Patient's own drugs	Other

Admission Medicines			Plan for medicines (Dr must complete)				Comments
Name	Dose	Freq	Continue	Amend	Suspend	Stop	Reason for alteration/other comments
Mirtazapine	15mg	Stopped					Stopped a few months ago (he was on it for a couple of weeks)

Pharmacy comments:

NHS

Emergency Department
Mental Health Triage and Risk Assessment

1203893450 12/03/1989 asgow de
WEIR
James

Patient Name _____

DoB _____ CHI _____

Emergency Department Triage

Triage Observations

GCS	BM	HR	BP	RR	SaO_2	Temp
		76	128/64	18	97%	36

Accompanied by

Police

Or describe the patient's physical appearance/clothing if attending alone as they may leave before assessment

Is the patient a young person in foster care or in a residential care placement? Yes (No)

Is the patient a carer for a child or for a dependent adult? Yes (No)

Is there a child protection concern or concern for an adult at risk? Yes (No)

Outline of Presentation

Overdose – will require medical assessment		
Self-Injury – will require wound management		
Other Mental Health Presentation	✓	

Initial Presentation, Appearance and Behaviour

Is the patient violent, aggressive or threatening?	Yes		(No)
Is the patient obviously distressed, markedly anxious or highly aroused?		Yes	(No)
Is the patient quiet and withdrawn?		Yes	(No)
Do you think the patient is behaving inappropriately to their situation?		Yes	(No)
Do you think the patient presents an immediate risk to you, to others, or to themselves?	Yes		(No)
Do you think the patient is likely to abscond prior to assessment?	Yes		(No)
Do you think the patient's presentation suggests either delusions or hallucinations?*	Yes		(No)
Do you think the patient's presentation suggests they feel their actions are being controlled?	Yes		(No)
Are you aware of a history of mental health problems or psychiatric illness?		(Yes)	No
Are you aware of a history of violence or self harm?		(Yes)	No
Is the patient currently expressing suicidal thoughts	(Yes)		No

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

Triage Risk Assessment

High/Moderate/Low Risk

of self-harm/violence/absconding in department

Triage Category		
	2	high risk – supervised *and* in the department moderate risk – supervised *or* in the department low risk – can be asked to wait if necessary

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

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

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

Immediate Management

Patient location, supervised by...	Room 4 - police		
Blood sample time?		Toxbase Information Printed?	

Print Name J Rae

Signature J Rae

Date 22/6/11 Time 15.30

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Emergency Department Mental Health Assessment

Outline of current presentation and precipitating factors

Previous mental health problems, self harm, addictions, medication etc

Other relevant information; relationships; finances, employment, housing, physical health, childcare etc

Appearance	Behaviour	Speech
Mood	Thought	Insight

Risk Assessment

High/Moderate/Low

Summary and Plan for Further Assessment

Summary

Service Referred to	Time of Referral

Discharge

Follow up and advice	Carer informed

Name and Designation of Consultant or Middle-Grade Involved in Reviewing Patient	

Risk Factors

male gender	y	n	u
age >18 and <65	y	n	u
depression	y	n	u
alcohol or drug use	y	n	u
separated, widowed, divorced	y	n	u
suicide plan/concealment	y	n	u
evidence of psychosis	y	n	u
ongoing suicial intent	y	n	u
lack of social support	y	n	u
chronic physical illness/pain	y	n	u
family history of suicide	y	n	u
family concerned about risk	y	n	u
disengaged/poor compliance	y	n	u
unemployed or retired	y	n	u
access to lethal means of harm	y	n	u
previous violent methods	y	n	u
history of self harm/overdose	y	n	u
previous psychiatric treatment	y	n	u
current psychiatric treatment	y	n	u
current use of benzodiazepines	y	n	u

If young people in foster or residential care are assessed, their social work team should be informed, (via standby SW if out-of-hours), *and* correspondence given to carers present.

Print Name _____

Signature _____

Date & Time _____

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Emergency Department Mental Health Triage and Risk Assessment

NHS Greater Glasgow and Clyde

1203893450 12/03/1989

Emergency Department Triage

Patient Name WEIR James

DoB

Triage Observations

GCS	BM	HR	BP	RR	SaO_2	Temp

Accompanied by

Or describe the patient's physical appearance/clothing if attending alone as they may leave before assessment

Is the patient a young person in foster care or in a residential care placement? Yes/No

Is the patient a carer for a child or for a dependent adult? Yes/No

Is there a child protection concern or concern for an adult at risk? Yes/No

Outline of Presentation

Overdose – will require medical assessment		
Self-Injury – will require wound management		
Other Mental Health Presentation		

Initial Presentation, Appearance and Behaviour

Is the patient violent, aggressive or threatening?	Yes		No
Is the patient obviously distressed, markedly anxious or highly aroused?		Yes	No
Is the patient quiet and withdrawn?		Yes	No
Do you think the patient is behaving inappropriately to their situation?		Yes	No
Do you think the patient presents an immediate risk to you, to others, or to themselves?	Yes		No
Do you think the patient is likely to abscond prior to assessment?	Yes		No
Do you think the patient's presentation suggests either delusions or hallucinations?*	Yes		No
Do you think the patient's presentation suggests they feel their actions are being controlled?	Yes		No
Are you aware of a history of mental health problems or psychiatric illness?		Yes	No
Are you aware of a history of violence or self harm?		Yes	No
Is the patient currently expressing suicidal thoughts	Yes		No

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

Triage Risk Assessment

High/Moderate/Low Risk

of self-harm/violence/absconding in department

Triage Category		
		high risk – supervised *and* in the department moderate risk – supervised *or* in the department low risk – can be asked to wait if necessary

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

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

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

Immediate Management

Patient location, supervised by…			
Blood sample time?		Toxbase Information Printed?	

Print Name

Signature

Date Time

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WITH POLICE — ESCORTED TO ED.

Emergency Department Mental Health Assessment

Outline of current presentation and precipitating factors (This form to be completed by medical staff)

CALLED CHARLESTON CENTRE AS NEEDED HELP W/ MENTAL HEALTH PROBLEMS. ADVISED ~~IHTT~~ TO ATTEND RAH ED. IHTT CONTACTED — DENY KNOWLEDGE OF PT. SAID SPOKE TO PERSON CALLED AMY WHO CALLED "STRUGGLING TO KEEP EMOTIONS AT BAY" POLICE AS CONCERNED HE "HAS IN POSSESSION OF FEELING LOW FOR MONTHS — TRIGGERED BY RELEASE OF PERSON ~~WHO~~ WHO KNIFE" ALLEGEDLY ABUSED HIM AT END OF LAST YR. Dx PTSD. PARTNER LEFT HIM. SOB FEELS SUICIDAL BUT ~~NOT~~ NO FIXED PLANS. CONSIDERED MULTIPLE METHODS.*

Previous mental health problems, self harm, addictions, medication etc

SAYS PTSD, PERSONALITY DISORDER, ANXIETY | SAYS NOT EATEN FOR MONTHS AND NEVER HAS APPETITE

HAD CPN (MARY MCKENZIE) BUT FEELS NO HELP. ~~DOESN'T~~ FEELS COULD BENEFIT FROM MH CPN.

DENIES ANY CURRENT ALCOHOL/DRUG USE — LAST SAW GLASGOW OCT 2016.

FORENSIC Hx: BARLINNIE & ENTERPRISE 10 Y.A.

* HAD FEELING A LOT OF ANGER & VIOLENT THOUGHTS TOWARDS ALLEGED ABUSER: SAYS HAS ARRANGED PEOPLE TO DRIVE HIM OUT OF TOWN. TO VISIT HIM TONIGHT

Other relevant information; relationships; finances, employment, housing, physical health, childcare etc

OUT OF LARGE FAMILY, ONLY IN TOUCH W/ SISTER IN SKEGNESS

UNEMPLOYED

LIVES ALONE — UNHAPPY W/ HOUSING SITUATION

Appearance	Behaviour	Speech
UNREMARKABLE	AGITATED, TEARFUL	FLIGHT OF IDEAS PRESSURED
Mood	**Thought**	**Insight**
LOW	HEARS VOICES	BUYS INTO HAVING "MENTAL HEALTH ISSUES"

Risk Assessment

By clinician undertaking the assessment, considering any previous assessments

High/Moderate/Low

Summary and Plan for Further Assessment

Referral to/liaison with psychiatry, community mental health services, MH addiction services etc

Summary IN CRISIS W/ MENTAL HEALTH. FEELS CHURCH R/ NOT HELPING & CURRENTLY NO CONTACT W/ C.P.N.

Service Referred to HAD CONTACTED COMMUNITY MH TEAM ADVISED ATTEND ED REFERRED IHTT

Time of Referral 1645

Discharge

Include the follow up plan, advice given, medications prescribed, referrals made

Follow up and advice

Carer informed

Name and Designation of Consultant or Middle-Grade Involved in Reviewing Patient

Risk Factors (yes / unknown)			
male gender	y	n	u
age >18 and <65	y	n	u
depression	y	n	u
alcohol or drug use	y	n	u
separated, widowed, divorced	y	n	u
suicide plan/concealment	y	n	u
evidence of psychosis	y	n	u
ongoing suicial intent	y	n	u
lack of social support	y	n	u
chronic physical illness/pain	y	n	u
family history of suicide	y	n	u
family concerned about risk	y	n	u
disengaged/poor compliance	y	n	u
unemployed or retired	y	n	u
access to lethal means of harm	y	n	u
previous violent methods	y	n	u
history of self harm/overdose	y	n	u
previous psychiatric treatment	y	n	u
current psychiatric treatment	y	n	u
current use of benzodiazepines	y	n	u

If young people in foster or resdential care are assessed, their social work team should be informed, (via standby SW if out-of-hours), *and* correspondence given to carers present.

Print Name JAMES PATTERSON

Signature

Date & Time

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Emergency Department Nursing Documentation

NHS Greater Glasgow and Clyde

aph Label
1203893450 12/03/1989
WEIR
James

Presenting Complaint: Suicidal.

Date and Time: 22.6.17 15:35

Named Nurse(s): J. COSSAR

Patient preparation (Please tick when completed)	Initials: JC	Communication (Please tick when completed)	Initials:
Prepare patient for examination and provide blankets if required	☑	Communication Aids (spectacles / hearing aid)	☐
Clothing bagged, labelled and stored under trolley	☐	Relatives present, who?	☐
Name-band (if required)	☑	Relatives / NOK Informed Police present	☑
		Interpreter required	☐
		Telephone interpretation required	☐

Observations and Investigations (Please tick when completed)		Initials:	
Vital Signs recorded on NEWS chart and NEWS score recorded. Record Pain, blood sugar and neuro obs on NEWS chart if appropriate.	☑	IV cannula (if required)	☐
Peak Flow 1. 2. 3.	☐	Blood samples taken	☐
12 Lead ECG	☐	Urinalysis and Specimen if indicated *Results:*	☐
Cardiac Monitoring	☐		
X-rays performed	☐	HCG specimen if indicated +ve ☐ -ve ☐ Strip Lot no:	☐
Other: please add	☐	Weight:	☐

Screening Tools (Please circle or tick as appropriate)		Initials:	
SEPSIS risk? SIRS Criteria 2 or more and suspicion of infection Sepsis 6 protocol initialise and departmental documentation started	Y (N) Y / N	**Preliminary Pressure Ulcer Risk Assessment** The patient can reposition themselves whilst in the department?	(Y) / N
AMT 4 (if >65 years) SCORE	/4	There is **no** reported skin damaged other than presenting trauma?	(Y) N
At risk of falls? (clinical judgement) (consider alcohol, mobility, age, illness, cognitive impairment etc). *If at risk complete risk assessment*	Y (N)	The person is fully continent? *If NO to any of the above initiate Waterlow risk assessment (within 4 hrs)*	(Y) N
Mental Health Triage Assessment	Y N	**Waterlow Score** *If >10 commence Active Care*	☐
Child Protection considered (in line with policy)	Y / N	**Active Care** (clinical judgement) (include all trolley patients at risk of pressure ulcers and all trolley patients in department for >4hrs) *Record on Active Care Chart*	☐
FAST	Y / N		
GMAWS	Y (N)	Pressure damage identified on arrival in ED is documented in clinical notes	☐
Has Swallow test been carried out?	Y / N	Grade 3 or 4 Pressure Ulcers are reported on DATIX	☐

Pause for Transfer (Please tick when completed)		Tick when completed	N/A	Notes
	Relatives informed	☐	☐	Information on discussion with relatives
	Cannula	☐	☐	
	Name band	☐	☐	
	AMT4	☐	☐	
	NEWS chart NEWS >7 - Name and Page number of senior doctor caring for patient	☐	Always	
Prescriptions signed	Infusions	☐	☐	
	Drugs	☐	☐	
	Allergies are recorded (e.g. on Kardex)	☐	☐	
	Fluids	☐	☐	
	Two hour plan in place e.g. Fluids, Antibiotics and emergency drugs written up on Kardex	☐	☐	
	GMAWS	☐	☐	
	Belongings (including patient's medications)	☐	Always	Please note here if any other tasks required prior to transfer
	Bed requested, accepted and ward informed	☐	Always	
	Notes: medical notes, GP letter, PRF	☐	Always	
Investigations	CXR reviewed	☐		
	ECG reviewed	☐	☐	Print name
	Bloods sent	☐	☐	
	Bloods reviewed	☐	☐	
	Patient on O_2: cylinder checked	☐	☐	
	Patients requiring analgesia: sufficient	☐	☐	



1203893450.
WEIR M
James 12/03/1989
27D MACDOWALL STREET
Johnstone, Renfrewshire
PA5 8QJ

Pause for Discharge (Please tick when completed)	Tick when completed	N/A	Notes
Advice leaflets given	☐	☐	Information on discussion with relatives
Belongings (including patient's medications)	☐	Always	
New medications explained	☐	☐	
Cannula removed	☐	☐	
Relatives aware of discharge	☐	☐	Please note here if any other tasks required prior to discharge
Social/ Support Services required and contacted	☐	☐	
SAS transport required and ref no	☐	☐	Print name
Other means of transport arranged by nurse	☐	☐	

Nursing Notes and Care Plan

Date and Time		Print Name and Signature
22.6.17 15:35	Into room with police. Pt wearing Rangers top, grey jogging bottoms. Shaved head, forearm tattoos.	
1700	Referred to 1411 - await review.	
24/6 1850	Police remain in attendance. Obsenations remain stable. S/B 1111 - await plan of care. No complaints offered.	(S/N)
1910	Care taken over by night shift, 1111 talking to Reg at present, Await decision	

Pa 1203893450

WEIR M
James 12/03/1989
27D MACDOWALL STREET
Johnstone, Renfrewshire
PA5 8QJ

Nursing Notes and Care Plan

Date and Time		Print Name and Signature

Emergency Department - Active Care

1203893450
WEIR M
James 12/03/1989
27D MACDOWALL STREET
Johnstone, Renfrewshire
PA5 8QJ

I have evaluated and deemed that the frequency of care delivery over the next work shift, based on the patient's most critical need should be every:

(Please circle) ½ hour 1hour 2 hours

Signed ..... Name G. McGREGOR

USE FOLLOWING CODE:

O = Off the ward V = Variant S = Sleeping I = Independent NT = No Thanks

			Time							
	1.	**PAIN: Assess and address** If in pain inform registered nurse Y/ N or N/A	N							
S	2.	**SKIN INSPECTION** Pressure areas checked: Y / N / I (independent)	I							
		Redness (R) / Discolouration (D) / Pressure Ulcer (PU) / Intact (INT)	INT							
K	3.	**KEEP MOVING:** Have you moved or walked Y / N / I (independent)	Y							
		Bed Right side (30° tilt) – R Left Side (30° tilt) – L Back– B	Sitting on chair							
		Chair Assist to walk, stand or tilt (W /ST/ T)	ST							
I	4.	**ELIMINATION:** Do you need the toilet? I = Independent A = Assistance given IC = patient incontinent of urine/faeces	I							
N	5.	**FOOD, FLUIDS AND NUTRITION:** Is the patient nil by mouth? Y / N (consider mouth care)	N							
		Encourage the patient to drink? (if appropriate) Y / N / N/A	Y							
		Food, snack or supplement taken? (if appropriate) Y / N / N/A	N/A							
	6.	**ENVIRONMENT:** Is the patient able to call for assistance? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position? (Y) N	Y							
	7.	**INFORMATION:** Ask: Is there anything else I can help you with? Inform patient of the time of return (Y) N	NT							
	8.	**ESCALATION:** Escalate any issues to the Registered Nurse? Y / N/A	N/A							
			Nurse Initials							

USE FOLLOWING CODE	Specialist Pressure Redistributing equipment	Variations			
V = Variant I = Independent NT = No thanks	☐ Repose Mattress ☐ Moving and handling aids ☐ Other:	Time	No.	Variation	Signed

Waterlow Pressure Area Risk Assessment

Build/Weight		Skin Type/Visual Risk Areas		Sex/Age		Special Risks - Tissue Malnutrition	
Average (BMI 20-24.9)	0	Healthy	0	Male	1	Multiple organ failure/ Terminal cachexia	8
Above Average (BMI 25-29.9)	1	Tissue Paper (thin/fragile)	1	Female	2		
Obese (BMI > 30)	2	Dry (appears flaky)	1	14-49	1	Single organ failure	5
Below Average (BMI < 20)	3	Oedematous (puffy)	1	50-64	2	Peripheral Vascular Disease	5
Continence		Clammy /pyrexia	1	65-74	3	Anaemia = Hb < 8	2
Complete/Catheterised	0	Discoloured (brusing/mottled)	2	75-80	4	Smoking	1
Incontinent urine	1			81+	5	**Neurofogical Deficit**	
Incontinent faeces	2	Broken (established ulcer)	3	**Nutritional Element**		Diabetes/MS/CVA Motor or sensory paraplegia (Max 6)	4-6
Doubly Incontinent (urine and faeces)	3	**Mobility**		Unplanned weight loss in past 3-6 months < 5% Score 0 5-10% Score 1 > 10% Score 2			
		Fully mobile	0			**Special Risks - Medication**	
Special Risks – Surgery/Trauma		Restless/Fidgety	1			Cytotoxic, anti-inflammatory, long term/high dose steroids (Max 4)	4
On table > 6 hours	8	Apathetic (sedated/depressed/ reluctant to move)	2				
Orthopaedic / below waist/Spinal (up to 48 hrs post-op)	5			BMI > 20 Score 0 BMI 18.5-20 Score 1 BMI < 18.5 Score 2			
On table > 2 hours (up to 48 hrs post op)	5	Bed bound (unconscious/unable to change position/traction)	4			Risk Score 10+ = 'At risk' 15+ = 'High Risk' 20+ = 'Very High Risk'	
		Chair Bound	5	Patient acutely ill or no nutritional intake > 5 days	2		

Patient's Initial Waterlow Score = If Score ≥10 Complete the Adapted Waterlow Pressure Area Risk Assessment Chart

NEWS – National Early Warning Score

NHS
Greater Glasgow and Clyde

Name
Address
1203893450
WEIR M
James 12/03/1989
27D MACDOWALL STREET
Johnstone, Renfrewshire
PA5 8QJ
CHI No.
DoB

	Date	Ward
Admitted	22/6/17	A16
Transferred		
Transferred		

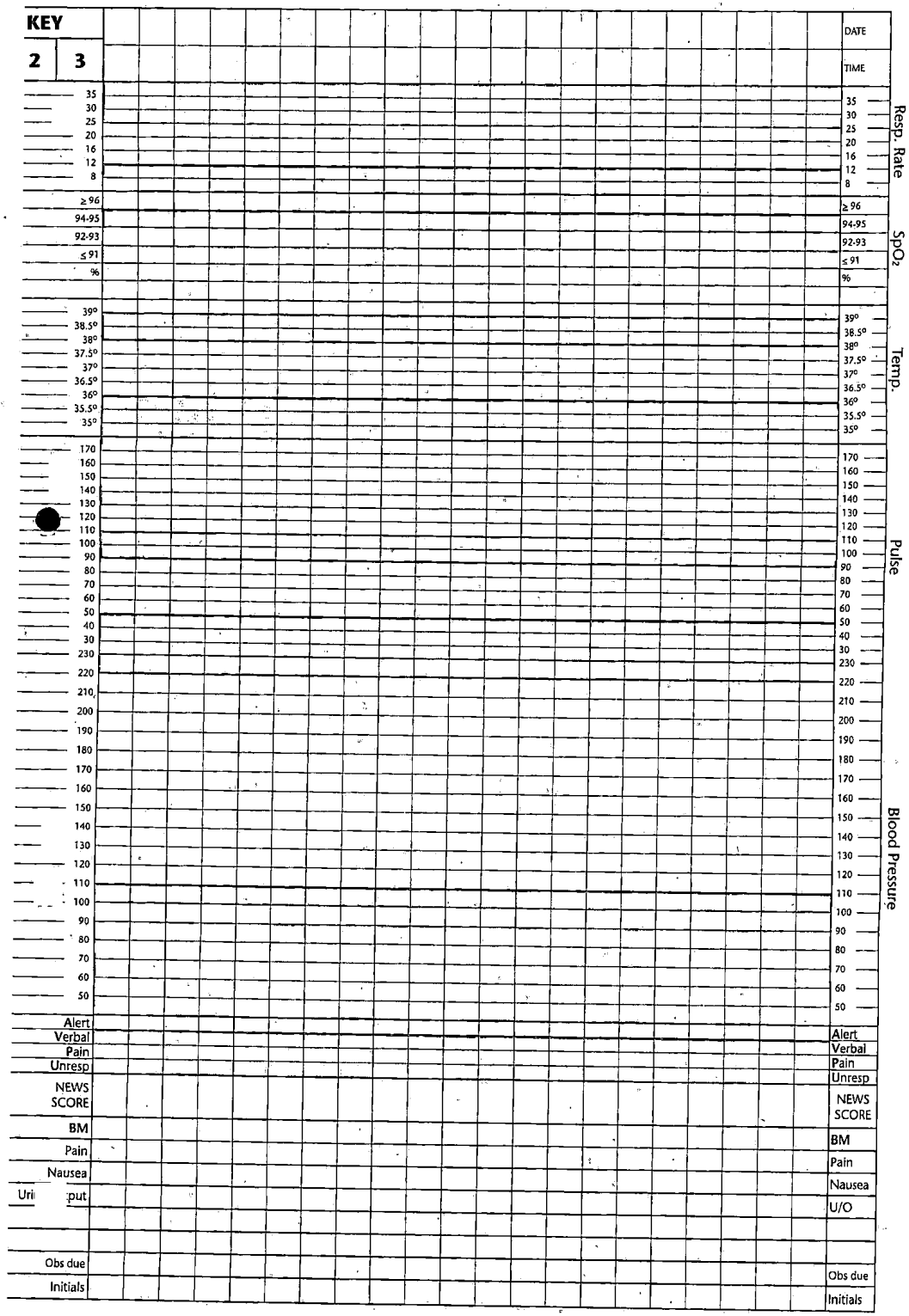
Physiological Parameter	NEWS – NHS Early Warning Score						
	3	2	1	0	1	2	3
Respiration Rate	≤8		9-11	12-20		21-24	≥25
Oxygen Saturations	≤91	92-93	94-95	≥96			
Any Supplemental Oxygen		Yes		No			
Temperature	≤35.0°		35.1-36.0°	36.1-38.0°	38.1-39°	≥39.1°	
Pulse	≤40		41-50	51-90	91-110	111-130	≥131
Systolic BP	≤90	91-100	101-110	111-219			≥220
Conscious Level				A			V, P or U

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

See NEWS Actions Reference Tool for local escalation policy

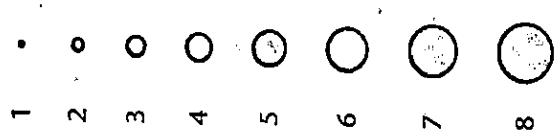
NEWS Score	Frequency of Monitoring	Clinical Response
0	Minimum 12 hourly	• Continue routine NEWS monitoring with every set of observations.
Aggregate 1- 4	Minimum 4 hourly	• Inform trained nurse. • Trained Nurse assessment: - Assess the patient - Review frequency of monitoring required - Assess need for escalation of clinical care and direct as appropriate.
Aggregate 5 or more or 3 in one parameter	Increased frequency to a minimum of 1 hourly	• Trained Nurse assessment. • Inform medical team caring for the patient. • Urgent assessment by a medical / surgical / nursing team with core competencies to assess acutely ill patients. • Consider level of monitoring required in relation to clinical care.
Aggregate 7 or more	Continuous monitoring of vital signs	• Trained Nurse to assess immediately. • Inform medical team caring for the patient – this should be at least senior medical staff level. • Emergency assessment by a clinical team with core competencies in the assessment of critically ill patients. This team will have critical care competencies and a practitioner/s with advanced airway skills and resuscitation skills. • Consider referral to high-dependency or ITU.

| | | |


KEY
2
3
DATE
TIME
Resp. Rate
35
30
25
20
16
12
8
SpO2
≥ 96
94-95
92-93
≤ 91
%
Temp.
39°
38.5°
38°
37.5°
37°
36.5°
36°
35.5°
35°
Pulse
170
160
150
140
130
120
110
100
90
80
70
60
50
40
30
Blood Pressure
230
220
210
200
190
180
170
160
150
140
130
120
110
100
90
80
70
60
50
Alert
Verbal
Pain
Unresp
NEWS SCORE
BM
Pain
Nausea
U/O
Obs due
Initials

Glasgow Coma Scale

Pupil size (mm)



1203893450
WEIR M
James 12/03/1989
27D MACDOWALL STREET
Johnstone, Renfrewshire
PA5 8QJ

Neurological Observations

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

Eyes closed by swelling = C

Endotracheal tube or tracheostomy = T

Usually record the best arm response

+ reacts – no reaction c. eyes closed

Record right (R) and left (L) separately if there is a difference between the two sides

Pain Score

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

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

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

Management Plan and Patient Exclusions

Date and Time	Notes	Signed

NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

11

Flagr
X-ray

CHI: 1203893450

Royal Alexandra Hospital

Total Att: **72**

12 Mth Att: **4**

Title: **MR**

WEIR **James**

DOB: **12/03/1989** Age: **28y** Sex: **Male**

27D MACDOWALL STREET

Johnstone
Renfrewshire
PA5 8QJ
07377865873

Next of kin: **WEIR, Deborah**
Relationship: **Sister**
07474837113

GP: **JC Sim**
01505 321733

Attendance Date: **09/06/2017** Arrival Time: **06:01**

Registration Time: **06:01** Date of Incident: **09/06/2017**

Major Incident Desc:

Reason for Attendance: **l/foot injury**

Affix Label

Nursing Assessment

Alerts: **Not Recorded**

Allergies: **Yes**

Pain Score:

Triage Category: **4**

Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: **09/06/2017 06:06**

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

Nurse name: **Nurse Ross MacInnes**

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

GCS	
Eyes	
Motor	
Verbal	
Total	

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

Nursing Notes: **Kicked door with instep R foot whilst at work yesterday. Since event c/o increased pain on mobilising. O/E swelling & bony tenderness medial malleolar zone & navicular R foot. Pedal pulse present, Sensation intact.**

Child Assessment Questionnaire

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

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

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

DO NOT WRITE HERE PLEASE

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

Date	CLINICAL NOTES
9/6/17	Seen by (Dr) STENHOUSE (ST6) Time seen

28y lo ♂.

1203893450 12/03/1989
WEIR
James

Kicked door yesterday as was angry

c/o pain medial arch of foot

Able to walk but c/o pain

Got bus here.

O/E/ Tender over medial arch but no pinpoint medial malleolar tenderness

No bony or MT tenderness

No lateral tenderness.

Some swelling inferior to medial malleolus.

Xray foot/ankle at triage.

— No new injury.

Old well corticated area inferior to medial malleolus are old —>

Date	CLINICAL NOTES
	Able to WB c some pain (P) Breg boot 1/52 for comfort Advice - NO F/U J Skinner SpR

Discharge Codes (Please CIRCLE)								Discharge date	
1. Admission	2. Discharge	3. Refer to GP	4. Transfer to other (see below)						
5. Died	6. Refer to OP Clinic (see below)		7. Irregular Discharge		8. D.O.A.			Discharge time	
Ward number (if admitted):			Transfer to hospital:					Consultant if admitted):	
Follow up	Arranged			Not arranged				To be arranged	
Clinic referred to	A&E	Hand injury	Fracture	Pop Check	Medical	Surgical	ENT	Others (specify):	

Discharge Prescription Packs

Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Frequency	Signature	Given By

NHS 24 FAX REPORT

Disc. 9/6.

NHS 24 ID:	Call ID: 19289729	Site:	Glasgow
CHI #:	1203893450	Caller Name:	
Surname:	WEIR	Date/Time Call Received:	08/06/2017 17:59
Forename:	JAMES		
DOB:	12/03/1989	Date Call Completed:	
Gender:	Male	Time Call Completed:	
Address:	Flat D	Call Priority:	CS0
	27 MacDowall Street	Call Reason:	ANKLE PAIN/BRUISING 3 HRS SEE AV
	Johnstone	Current Location:	Flat D
			27 MacDowall Street
	Renfrewshire/PA5 8QJ		Johnstone
PH NO:	07377865873 (Return)		Renfrewshire/PA5 8QJ
		Special Directions:	Intercom/Buzzer Entry
		Current PH NO:	07377865873 (Return)
Care Provider:	SIM, JULIET	Care Provider Details:	QUARRYSIDE MED PRACTICE LINDEN MED CTR, FLOORS ST JOHNSTONE PA5 8PZ Scotland
Temporary Resident:	No		

Referred To:	Glasgow and Clyde Hub	Recommended Action:	Pt advised to go to A&E - For Information Only

CLINICAL SUMMARY

ANKLE INJURY FOR 3 HRS AND KICKED GLASS DOOR . UNABLE TO WEIGHTBEAR DUE TO SEVERE PAIN . RED AND VERY SWOLLEN . TAKEN IBUPROFEN . RAH A&E 4HRS .

PAST MEDICAL HISTORY

MEDICAL PROBLEMS

? STOMACH ULCER, IRREGULAR HEART BEAT, DEPRESSION, PSH, ANXIETY, ALCHOL ABUSE

MEDICATIONS

VENLAFAXINE (UNCERTAIN OF DOSE)

ALLERGIES

PENICILLIN

Referred Clinical Notes:

T:
P:
R:
BP: /

Print Name:

Signature:

NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

Affix Label

CHI: 1203893450

Royal Alexandra Hospital

Total Att: 71

12 Mth Att: 5

Title: **MR**

WEIR **James**

DOB: **12/03/1989** Age: **27y** Sex: **Male**

27D MACDOWALL STREET

Johnstone
Renfrewshire
PA5 8QJ
07474837113

Next of kin: **WEIR, Deborah**
Relationship: **Sister**
07474837113

GP: **EC Renwick**
01505 321733

Attendance Date: **19/09/2016** Arrival Time: **11:29**

Registration Time: **11:29** Date of Incident: **19/09/2016**

Major Incident Desc:

Reason for Attendance: **right foot pain**

Affix Label

Nursing Assessment

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

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

Presenting Complaint:

Observation Date: **19/09/2016 11:38** Nurse name: **Dr Monica Wallace**

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

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

GCS	
Eyes	
Motor	
Verbal	
Total	

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

Nursing Notes:

kicked set of drawers yesterday, pain (R) foot weight bearing.

Child Assessment Questionnaire

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

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

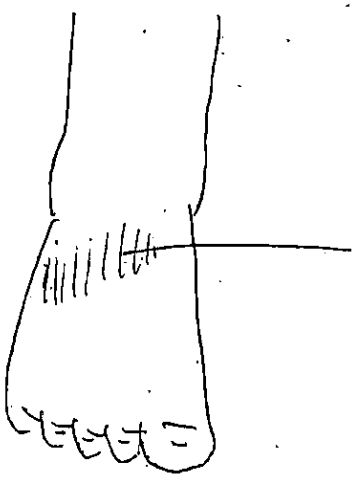
X-Ray and Other Reports to be filed on this side (if the patient is not being admitted)

DO NOT WRITE HERE PLEASE

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

Date	CLINICAL NOTES
	Seen by (Dr) YOUNG — Time seen
14/9/16	27 ♂
1220	Kicked chest of banners in fell of rage last night

1203893450 12/03/1989
WEIR
James



Bruise, tenderness,

Ankle

X-ray foot: ↓ Cuboid

Rx analgesia

Dr Young

Date	CLINICAL NOTES

Discharge Codes (Please CIRCLE)								Discharge date	
1. Admission	2. Discharge	3. Refer to GP	4. Transfer to other (see below)						
5. Died	6. Refer to OP Clinic (see below)		7. Irregular Discharge		8. D.O.A.			Discharge time	

Ward number (if admitted):	Transfer to hospital:	Consultant If admitted):

Follow up	Arranged			Not arranged				To be arranged
Clinic referred to	A&E	Hand injury	Fracture	Pop Check	Medical	Surgical	ENT	Others (specify):

Discharge Prescription Packs

Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Frequency	Signature	Given By
19/4/16	Co Codamol 30/500	1	O	PRN		

NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

Affix Label

CHI: 1203893450

Royal Alexandra Hospital

Total Att: **70**

12 Mth Att: **4**

Title: **MR**

WEIR **James**

DOB: **12/03/1989** Age: **27y** Sex: **Male**

27D MACDOWALL STREET

Johnstone
Renfrewshire
PA5 8QJ
07474837113

Next of kin: **WEIR, Deborah**
Relationship: **Sister**
0758859964

GP: **EC Renwick**
01505 321733

Attendance Date: **16/08/2016** Arrival Time: **02:26**

Registration Time: **02:26** Date of Incident: **16/08/2016**

Major Incident Desc:

Reason for Attendance: **abdo pain**

Affix Label

Nursing Assessment

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

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

Presenting Complaint:

Observation Date: **16/08/2016 02:35** Nurse name: **Nurse Catriona Livingston**

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

BM		mmol/L
PF		1/min
Expected PF		1/min
Weight		kg
Height		cm
Visual Acuity		
Left		
Right		
Corrected?		

GCS	
Eyes	
Motor	
Verbal	
Total	

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

Nursing Notes: **"c/o upper L abdo pain since 01.45hrs, no vomiting. "**

Child Assessment Questionnaire

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

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

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

DO NOT WRITE HERE PLEASE

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

Date	CLINICAL NOTES
	Seen by (Dr) Time seen

16/8

0400

Manson AS

1203893450 12/03/1989
WEIR
James

27 07

Sudden onset of LBP Nausea Vomit Clot
pain at 0030

Felt SOB.

No cough No haemoptysis

PMH Depression

DH MeDA Sx Constipation
Ibuprofen No change in
Chlorpromazine Morphine

O/E Well

A Pleuritic

A [redacted] Clot clear
Resp 15 Sp02 98% RA
No added

C BP- 120/70 P 84
Cent cap CRT <2s

Date	CLINICAL NOTES
	ⓓ Ⓐ v pu Ⓒ Abbo adh BJ— No cmpr hx ECG ① SR ST N ants QTc ⓝ → Plenty → Admit Amox mony. stbns Home GT none

Discharge Codes (Please CIRCLE)					Discharge date	
1. Admission	2. ~~Discharge~~	3. Refer to GP	4. Transfer to other (see below)			
5. Died	6. Refer to OP Clinic (see below)		7. Irregular Discharge	8. D.O.A.	Discharge time	

Ward number (if admitted):	Transfer to hospital:	Consultant If admitted):

Follow up	Arranged		Not arranged				To be arranged
Clinic referred to	A&E	Hand injury	Fracture	Pop Check	Medical	Surgical	ENT	Others (specify):

Discharge Prescription Packs

Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Frequency	Signature	Given By
6/9	VALPROATE	500mg	PO	bd		R English
16/9	CO-AMOXICLAV 625	2 tabs	PO	tds		R English

Emergency Department Nursing Documentation

(A)

NHS Greater Glasgow and Clyde

Patient Addressograph Label

1203893450 12/03/1989
WEIR
James

Presenting Complaint: Abdo pain

Date and Time: 16/8/16 0320

Named Nurse(s): M McCafferty.

Patient preparation (Please tick when completed)	Initials: MM	Communication (Please tick when completed)	Initials: MM
Prepare patient for examination and provide blankets if required	☑	Communication Aids (spectacles / hearing aid)	☑
Clothing bagged, labelled and stored under trolley	☑	Relatives present, who?	☒
Name-band (if required) NKDA.	☑	Relatives / NOK informed	☑
		Interpreter required	☐ N/A
		Telephone interpretation required	☐ N/A

Observations and Investigations (Please tick when completed)		Initials:	
Vital Signs recorded on NEWS chart and NEWS score recorded. Record Pain, blood sugar and neuro obs on NEWS chart if appropriate.	☑	IV cannula (if required)	☐
Peak Flow 1. 2. 3.	☐	Blood samples taken	☐
12 Lead ECG	☐	Urinalysis and Specimen if indicated *Results:*	☐
Cardiac Monitoring	☐		
X-rays performed	☐	HCG specimen if indicated +ve ☐ -ve ☐ Strip Lot no:	☐
Other: please add	☐	Weight:	☐

Screening Tools (Please circle or tick as appropriate)		Initials: MM	
SEPSIS risk? SIRS Criteria 2 or more and suspicion of infection Sepsis 6 protocol initialise and departmental documentation started	Y (N) Y (N)	**Preliminary Pressure Ulcer Risk Assessment** The patient can reposition themselves whilst in the department?	Y N
AMT 4 (if >65 years) SCORE	/4	There is **no** reported skin damaged other than presenting trauma?	(Y) N
At risk of falls? (clinical judgement) (consider alcohol, mobility, age, illness, cognitive impairment etc). *If at risk complete risk assessment*	Y (N)	The person is fully continent? *If NO to any of the above initiate Waterlow risk assessment (within 4 hrs)*	(Y) N
Mental Health Triage Assessment	Y (N)	**Waterlow Score** *If >10 commence Active Care*	☐
Child Protection considered (in line with policy)	Y (N)	**Active Care** (clinical judgement) (include all trolley patients at risk of pressure ulcers and all trolley patients in department for >4hrs) *Record on Active Care Chart*	☐
FAST	Y (N)		
GMAWS	Y (N)	Pressure damage identified on arrival in ED is documented in clinical notes	☐ N/A
Has Swallow test been carried out?	Y (N)	Grade 3 or 4 Pressure Ulcers are reported on DATIX	☐ N/A

Pause for Transfer (Please tick when completed)		Tick when completed	N/A	Notes
	Relatives informed	☐	☐	Information on discussion with relatives
	Cannula	☐	☐	
	Name band	☐	☐	
	AMT4	☐	☐	
	NEWS chart NEWS >7 - Name and Page number of senior doctor caring for patient	☐	Always	
Prescriptions signed	Infusions	☐	☐	
	Drugs	☐	☐	
	Allergies are recorded (e.g. on Kardex)	☐	☐	
	Fluids	☐	☐	
	Two hour plan in place e.g. Fluids, Antibiotics and emergency drugs written up on Kardex	☐	☐	
	GMAWS	☐	☐	
	Belongings (including patient's medications)	☐	Always	Please note here if any other tasks required prior to transfer
	Bed requested, accepted and ward informed	☐	Always	
	Notes: medical notes, GP letter, PRF	☐	Always	
Investigations	CXR reviewed	☐		
	ECG reviewed	☐	☐	Print name
	Bloods sent	☐	☐	
	Bloods reviewed	☐	☐	
	Patient on O_2: cylinder checked	☐	☐	
	Patients requiring analgesia: sufficient	☐	☐	

mi • 262617 Version 1_0 • GGC0107

Patient Addressograph Label

Pause for Discharge (Please tick when completed)	Tick when completed	N/A	Notes
Advice leaflets given	☐	☑	Information on discussion with relatives
Belongings (including patient's medications)	☑	Always	
New medications explained	☑	☐	
Cannula removed	☐	☑	
Relatives aware of discharge	☐	☑	Please note here if any other tasks required prior to discharge
Social/ Support Services required and contacted	☐	☑	
SAS transport required and ref no	☐	☑	Print name R English
Other means of transport arranged by nurse	☐	☑	

Nursing Notes and Care Plan

Date and Time		Print Name and Signature
16/8	Patient into room, prep for exam c/B ED	mm
	D/sch/gd home with prescribed medications	R English

Patient Addressograph Label

1203893450 12/03/1989
WEIR
James

Nursing Notes and Care Plan

Date and Time		Print Name and Signature

Emergency Department - Active Care

I have evaluated and deemed that the frequency of care delivery over the next work shift, based on the patient's most critical need should be every:

(Please circle) ½ hour 1hour 2 hours

Signed ..... Name .....

Patient Addressograph Label

USE FOLLOWING CODE:

O = Off the ward V = Variant S = Sleeping I = Independent NT = No Thanks

			Time							
	1.	**PAIN:** Assess and address If in pain inform registered nurse Y/ N or N/A								
S	2.	**SKIN INSPECTION** Pressure areas checked: Y / N / I (independent)								
		Redness (R) / Discolouration (D) / Pressure Ulcer (PU) / Intact (INT)								
K	3.	**KEEP MOVING:** Have you moved or walked Y / N / I (independent)								
		Bed Right side (30° tilt) – R Left Side (30° tilt) – L Back– B								
		Chair Assist to walk, stand or tilt (W /ST/ T)								
I	4.	**ELIMINATION:** Do you need the toilet? I = Independent A = Assistance given IC = patient incontinent of urine/faeces								
N	5.	**FOOD, FLUIDS AND NUTRITION:** Is the patient nil by mouth? Y / N (consider mouth care)								
		Encourage the patient to drink? **(If appropriate)** Y / N / N/A								
		Food, snack or supplement taken? **(If appropriate)** Y / N / N/A								
	6.	**ENVIRONMENT:** Is the patient able to call for assistance? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position? Y / N								
	7.	**INFORMATION:** Ask: Is there anything else I can help you with? Inform patient of the time of return. Y / N								
	8.	**ESCALATION:** Escalate any issues to the Registered Nurse? Y / N/A								
			Nurse Initials							

USE FOLLOWING CODE	Specialist Pressure Redistributing equipment	Variations			
V = Variant I = Independent NT = No thanks	☐ Repose Mattress ☐ Moving and handling aids ☐ Other:	Time	No.	Variation	Signed

Waterlow Pressure Area Risk Assessment

Build/Weight		Skin Type/Visual Risk Areas		Sex/Age		Special Risks - Tissue Malnutrition	
Average (BMI 20-24.9)	0	Healthy	0	Male	1	Multiple organ failure/ Terminal cachexia	8
Above Average (BMI 25-29.9)	1	Tissue Paper (thin/fragile)	1	Female	2		
Obese (BMI > 30)	2	Dry (appears flaky)	1	14-49	1	Single organ failure	5
Below Average (BMI < 20)	3	Oedematous (puffy)	1	50-64	2	Peripheral Vascular Disease	5
Continence		Clammy /pyrexia	1	65-74	3	Anaemia = Hb < 8	2
Complete/Catheterised	0	Discoloured (brusing/mottled)	2	75-80	4	Smoking	1
Incontinent urine	1			81+	5	**Neurological Deficit**	
Incontinent faeces	2	Broken (established ulcer)	3	**Nutritional Element**		Diabetes/MS/CVA Motor or sensory paraplegia (Max 6)	4-6
Doubly Incontinent (urine and faeces)	3	**Mobility**		Unplanned weight loss in past 3-6 months < 5% Score 0 5-10% Score 1 > 10% Score 2			
Special Risks – Surgery/Trauma		Fully mobile	0			**Special Risks - Medication**	
On table > 6 hours	8	Restless/Fidgety	1			Cytotoxic, anti-inflammatory, long term/high dose steroids (Max 4)	4
Orthopaedic / below waist/Spinal (up to 48 hrs post-op)	5	Apathetic (sedated/depressed/ reluctant to move)	2				
On table > 2 hours (up to 48 hrs post op)	5	Bed bound (unconscious/unable to change position/traction)	4	BMI > 20 Score 0 BMI 18.5-20 Score 1 BMI < 18.5 Score 2		Risk Score 10+ = 'At risk' 15+ = 'High Risk' 20+ = 'Very High Risk'	
		Chair Bound	5	Patient acutely ill or no nutritional intake > 5 days	2		

Patient's Initial Waterlow Score = If Score ≥ 10 Complete the Adapted Waterlow Pressure Area Risk Assessment Chart

NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

Name	
Address	
	1203893450 12/03/1989 WEIR James
CHI No.	
DoB	

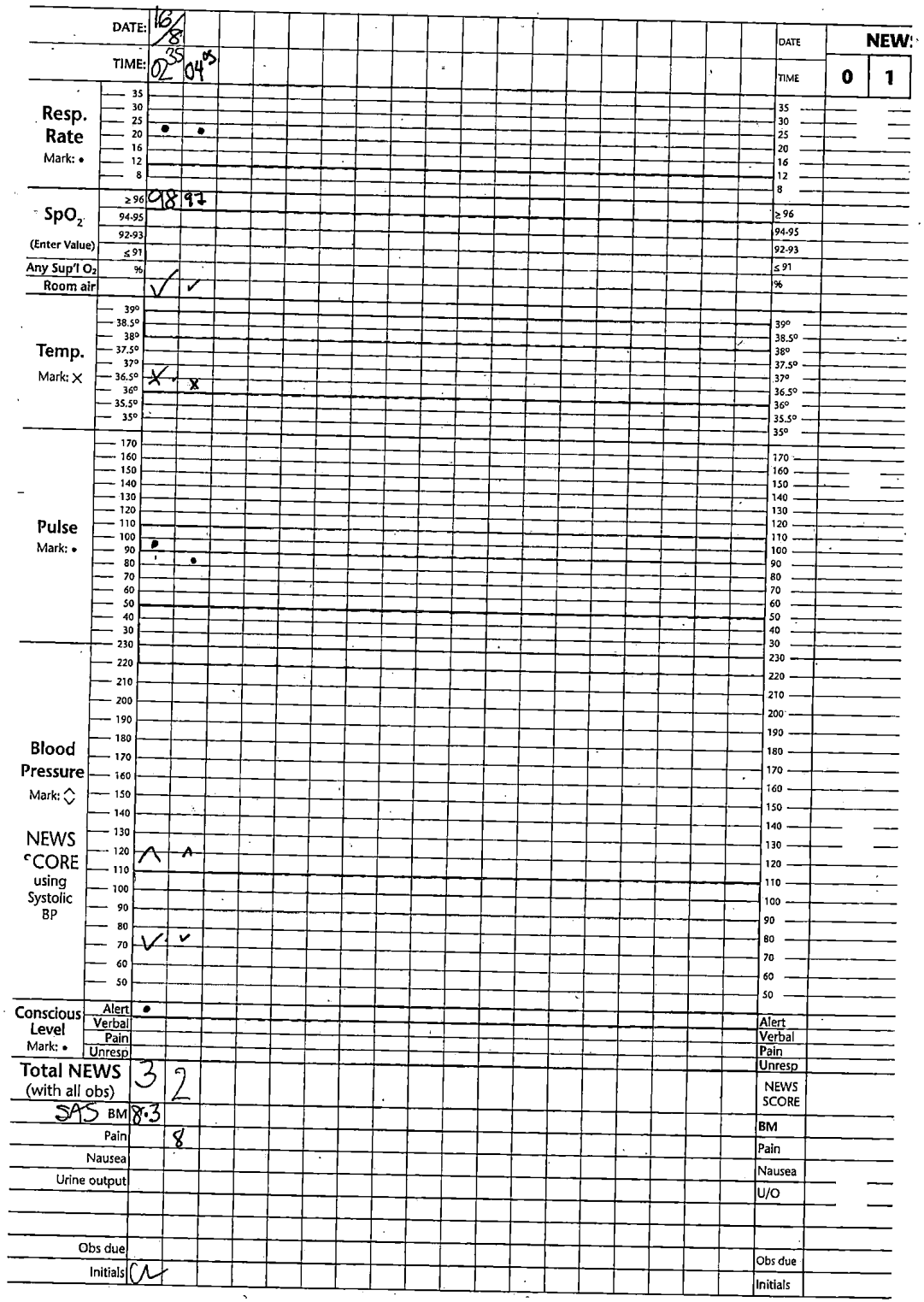
	Date	Ward
Admitted	16.8.16	AE
Transferred		
Transferred		

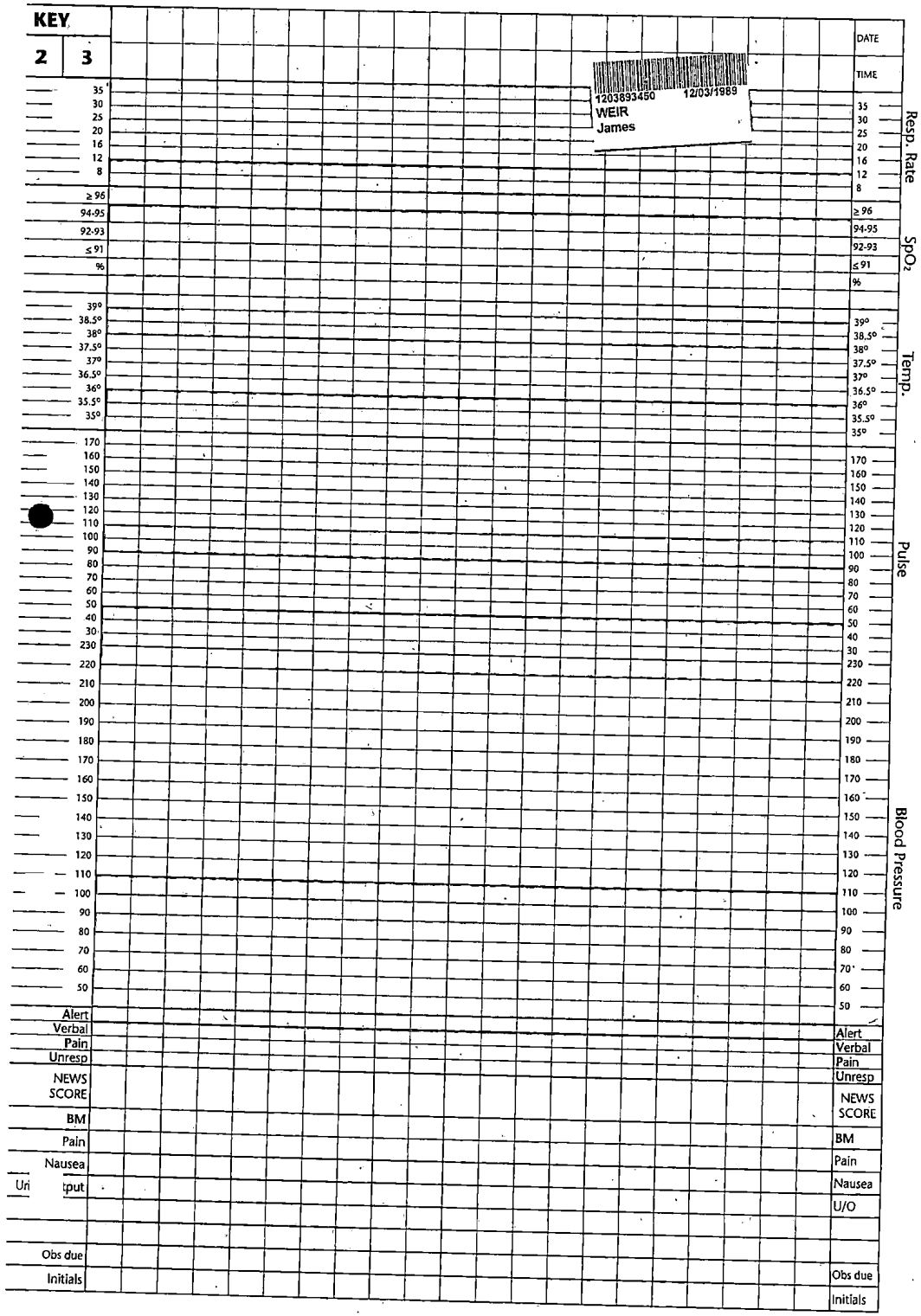
Physiological Parameter	NEWS – NHS Early Warning Score						
	3	2	1	0	1	2	3
Respiration Rate	≤8		9-11	12-20		21-24	≥25
Oxygen Saturations	≤91	92-93	94-95	≥96			
Any Supplemental Oxygen		Yes		No			
Temperature	≤35.0°		35.1-36.0°	36.1-38.0°	38.1-39°	≥39.1°	
Pulse	≤40		41-50	51-90	91-110	111-130	≥131
Systolic BP	≤90	91-100	101-110	111-219			≥220
Conscious Level				A			V, P or U

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

See NEWS Actions Reference Tool for local escalation policy

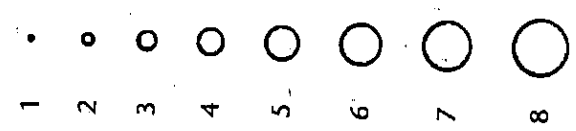
NEWS Score	Frequency of Monitoring	Clinical Response
0	Minimum 12 hourly	• Continue routine NEWS monitoring with every set of observations.
Aggregate 1- 4	Minimum 4 hourly	• Inform trained nurse. • Trained Nurse assessment: - Assess the patient - Review frequency of monitoring required - Assess need for escalation of clinical care and direct as appropriate.
Aggregate 5 or more or 3 in one parameter	Increased frequency to a minimum of 1 hourly	• Trained Nurse assessment. • Inform medical team caring for the patient. • Urgent assessment by a medical / surgical / nursing team with core competencies to assess acutely ill patients. • Consider level of monitoring required in relation to clinical care.
Aggregate 7 or more	Continuous monitoring of vital signs	• Trained Nurse to assess immediately. • Inform medical team caring for the patient – this should be at least senior medical staff level. • Emergency assessment by a clinical team with core competencies in the assessment of critically ill patients. This team will have critical care competencies and a practitioner/s with advanced airway skills and resuscitation skills. • Consider referral to high dependency or ITU.


DATE: 16/8
TIME: 0235 0405
Resp. Rate
Mark: •
SpO2
(Enter Value)
Any Sup'l O2
Room air
Temp.
Mark: ×
Pulse
Mark: •
Blood Pressure
Mark: ◇
NEWS SCORE using Systolic BP
Conscious Level
Mark: •
Alert
Verbal
Pain
Unresp
Total NEWS (with all obs)
3
2
SAS BM
8.3
Pain
8
Nausea
Urine output
Obs due
Initials
DATE
TIME
NEWS
0
1
NEWS SCORE
BM
Pain
Nausea
U/O
Obs due
Initials


KEY
2
3
1203893450
12/03/1989
WEIR
James
DATE
TIME
Resp. Rate
SpO2
Temp.
Pulse
Blood Pressure
35
30
25
20
16
12
8
≥ 96
94-95
92-93
≤ 91
%
39°
38.5°
38°
37.5°
37°
36.5°
36°
35.5°
35°
170
160
150
140
130
120
110
100
90
80
70
60
50
40
30
230
220
210
200
190
180
170
160
150
140
130
120
110
100
90
80
70
60
50
Alert
Verbal
Pain
Unresp
NEWS SCORE
BM
Pain
Nausea
Urine Output
Obs due
Initials

Glasgow Coma Scale

Pupil size (mm)



Neurological Observations

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

Eyes closed by swelling = C

Endotracheal tube or tracheostomy = T

Usually record the best arm response

+ reacts
– no reaction
c. eyes closed

Record right (R) and left (L) separately if there is a difference between the two sides

Pain Score

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

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

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

Management Plan and Patient Exclusions

Date and Time	Notes	Signed

Scottish Ambulance Service Patient Report Form

Incident Number	CR003139032 on 16/08/2016 at 01:32		
Callsign		Incident Type	EMG
Crew1	E0022616 - Driver	Crew3	
Crew2	E0031151 - Attendant	Crew4	

INCIDENT LOG

Incident Location	FLAT D 27 MACDOWALL STREET JOHNSTONE	Incident Postcode	PA5 8QJ
Call Received	01:32 - 16/08/2016	Patient at Hospital	-
Call Passed	01:34 - 16/08/2016	Patient Handover	-
Crew Mobile	01:37 - 16/08/2016	Crew Clear	-
Crew at Scene	01:56 - 16/08/2016	Clear Reason	
Crew Left Scene	02:03 - 16/08/2016		
Receiving Hospital	ROYAL ALEXANDRA - PAISLEY		

DIAGNOSIS

Chief Complaint Code	GPA
Despatch Code	33C04 : Transfer - Possible Acute Heart Problem or MI
Diagnostic Code	01A01 : 01A01 - Abdominal Pain

PATIENT DETAILS

Surname	WEIR		
Forename	JAMES		
Middle Initials		Sex	Male
DoB	12/03/1989	Age	27y
Patient Address		Patient Postcode	
Patient Telephone		Ethnicity	
CHI Number	1203893450		

PRIMARY SURVEY

AVPU Assessment	Alert
Catastrophic Haemorrhage	No
Airway Assessment	Clear
Breathing Rate	Fast
Respiratory Rate	22
Pulse	Fast
Most Peripheral Palpable Pulse Found	Radial
Skin Colour	Normal
Skin Texture	Dry
Capillary Refill Rate	< 2 Secs
CSI Assessment	None

VITAL SIGNS

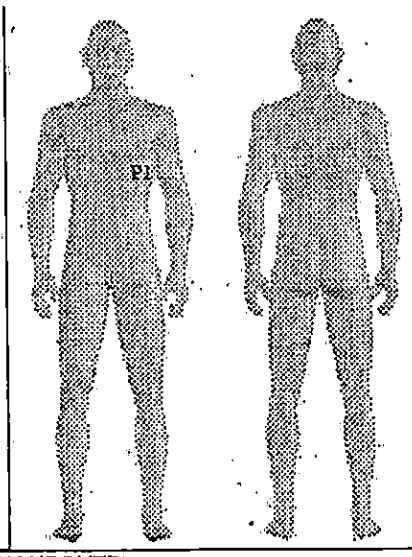
Time	Pulse	Rthm	AVPU	RR	SYS	DIA	PEF	BG	Temp	SpO2	PS	CRT	ECG	Sepsis	GCS	RTS	NEWS	ETCO2	Lactate
02:01	105	Reg	Alert	22	117	82		8.3	36.5	99	7	< 2 Secs	Sinus tachycardia	3	15	7.8	3		
02:06	103	Reg	Alert	20	128	80				99	5	< 2 Secs	Sinus tachycardia	1	15	7.8	1		
02:11	100	Reg	Alert	19	124	75				99	5	< 2 Secs	Normal sinus rhythm	1	15	7.8	1		

AMPLE

Allergy Type	None
Previous Medication	VARIOUS
Previous Medical History	MENTAL HEALTH PROBS
Disability	Mental Health Condition
Last Eaten Before Incident	1 Hour

EYES AND PUPILS

Left Eye		Right Eye	
Left Pupil Size	Dilated	Right Pupil Size	Dilated
Left Pupil Reaction	Normal	Right Pupil Reaction	Normal
Unequal Reaction To Light			



PATIENT HANDOVER

Patient Mobility On Arrival	Seated	On Scene Removal	Walking
Patient Transportation	Seated	Care Delivery At Hospital	Chair
Time Of Patient Handover			

SEPSIS

Pulse	RR	SYS	Temp	GCS	BG	Pneumonia	UTI	Other infection	Abdo Pain	Diarrhoea	Abdo distension	Meningitis	Cellulitis	Septic arthritis	Wound infection	Infected indwelling device	No signs of infection
105	22	117	36.5	15	8.3	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	YES
103	20	128		15		NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	YES
100	19	124		15		NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	YES

GCS

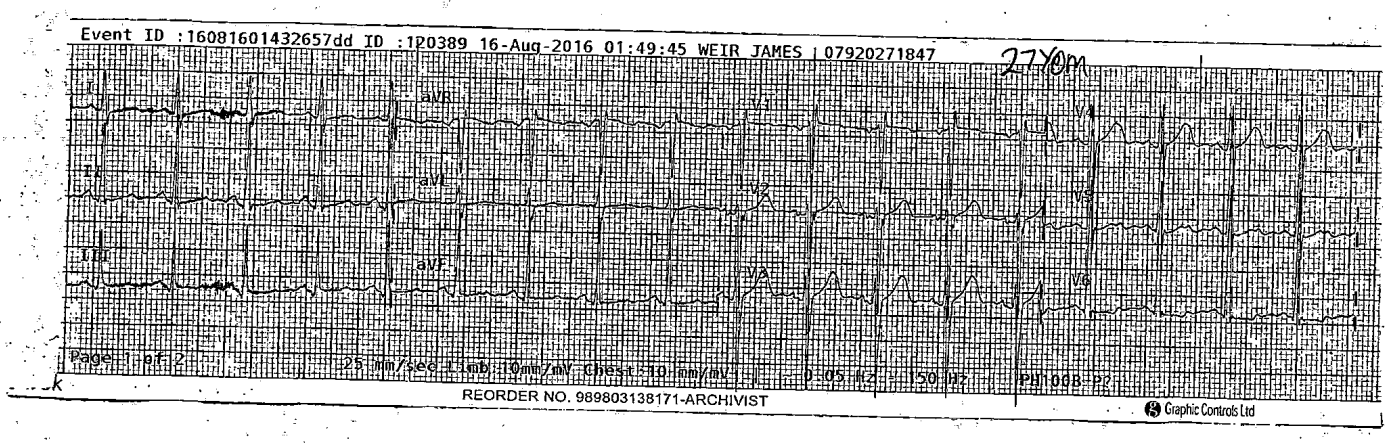
Time	Eye Opening	Verbal Response	Motor Response	Total
02:01	Spontaneous	Orientated	Obeys Commands	15
02:06	Spontaneous	Orientated	Obeys Commands	15
02:11	Spontaneous	Orientated	Obeys Commands	15

ADDITIONAL COMMENTS AND OBSERVATIONS

JAMES HAS DEVELOPED UPPER (L) QUAD ABDO/CHEST PAIN AROUND 01:45 THIS MORNING PAIN WORSE ON INHILATION , O/E > REPS AND PULSE ALL OTHER OBS NORMAL ,

REPORT MANAGEMENT

Report ID	CR003139032-16082016021604		
Software Version	1.0.440	Report Type	Interim



CHI - 120389345O

01[43] P130 QRS 123/73 99%
ST 8/10 36.5 8.3
Chest clear, worse on deep inhalation.
01[53] P105 QRS 117/82 99%
ST 8/10

NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

Affix Label

CHI: 1203893450

Royal Alexandra Hospital

Total Att: 69

12 Mth Att: 3

Title: MR

WEIR **James**

DOB: **12/03/1989** Age: **27y** Sex: **Male**

27D MACDOWALL STREET

Johnstone
Renfrewshire
PA5 8QJ
07474837113

Next of kin: **WEIR, Deborah**
Relationship: **Sister**
0758859964

GP: **EC Renwick**
01505 321733

Attendance Date: **11/08/2016** Arrival Time: **10:55**

Registration Time: **10:55** Date of Incident: **11/08/2016**

Major Incident Desc:

Reason for Attendance: **suicidal**

Affix Label

Nursing Assessment

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

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

Presenting Complaint:

Observation Date: **11/08/2016 10:57** Nurse name: **Nurse Tracy Smith**

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

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

GCS	
Eyes	
Motor	
Verbal	
Total	

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

Nursing Notes: **hearing voices telling him to kill himself and others. Hx mental health denies alcohol or substance abuse**

Child Assessment Questionnaire

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

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

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

DO NOT WRITE HERE PLEASE

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

Date	CLINICAL NOTES
	Seen by (Dr) — Time seen
11.08.16	I.H.T.T.
14.40	SpR/P B.GIBSON
	ST/N S.GALLAGHER

1203893450 12/03/1989
WEIR
James

Assessed by I.H.T.T. still citing suicidal ideation and plan to cut wrists with a Stanley knife. Also voiced that he may attack/harm his mother, the man who allegedly raped him. Has disclosed to staff he is in possession of a 9mm gun - we have told accompanying police of this.
Will not contract to safety. T/c to on call consultant Dr S. Shivaprasad.
Due to risk - admit to hospital (Psychiatric)
* Please note - no evidence of any psychotic symptoms
- No evidence of being under the influence of drugs/alcohol.
- Police will escort patient to Dykebar. SCN PRACTITIONER
- Discharge if medically fit.

BGIBSON BGibson

Date	CLINICAL NOTES

Discharge Codes (Please CIRCLE)				Discharge date	
1. Admission	2. Discharge	3. Refer to GP	4. Transfer to other (see below)		
5. Died	6. Refer to OP Clinic (see below)	7. Irregular Discharge	8. D.O.A.	Discharge time	

Ward number (if admitted):	Transfer to hospital:	Consultant If admitted):

Follow up	Arranged			Not arranged			To be arranged	
Clinic referred to	A&E	Hand injury	Fracture	Pop Check	Medical	Surgical	ENT	Others (specify):

Discharge Prescription Packs

Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Frequency	Signature	Given By

Glasgow Emergency Departments
Mental Health Triage and Risk Assessment

this side to be completed by triage nurse

1203893450 12/03/1989
name WEIR James
DoB
CHI

1. Triage observations

document physiological measurements

GCS	BM	HR	BP	RR	SaO^2	Temp

Accompanied by...

name/relationship/medical concerns

With Police.

briefly describe patients attending alone (they may leave before assessment)

2. Outline of presentation

tick all those categories which apply and provide a brief summary

overdose – will require medical assessment		
self-injury - will require wound management		
other mental health presentation	✓	

3. Initial presentation, appearance and behaviour

respond yes or no to each question

Is the patient violent, aggressive or threatening?	Yes		(No)
Is the patient obviously distressed, markedly anxious or highly aroused?		(Yes)	No
Is the patient quiet and withdrawn?		Yes	(No)
Do you think the patient is behaving inappropriately to their situation?		Yes	(No)
Do you think the patient presents an immediate risk to you, to others, or to themselves?	(Yes)		(No)
Do you think the patient is likely to abscond prior to assessment?	Yes		(No)
Do you think the patient's presentation suggests either delusions or hallucinations?*	(Yes)		No
Do you think the patient's presentation suggests they feel their actions are being controlled?	(Yes)		No
Are you aware of a history of violence or self harm?		(Yes)	No
Are you aware of a history of mental health problems or psychiatric illness?		(Yes)	No

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

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

other patients can be categorized as **Moderate Risk**

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

4. Triage Risk Assessment

find and state the category of risk by circling and selecting one bold risk

High / Moderate / Low risk

of self-harm/violence/absconding in department

Triage Category		
	2	high risk – supervised *and* in the department moderate risk – supervised *or* in the department low risk – can be asked to wait if necessary

5. Immediate management

e.g. print toxbase information and if paracetamol overdose document 4 hour time in chart

Patient location, supervised by...			
blood sample time?		toxbase information printed?	

print name J CASSIDY

signature

date 11/8/16 time 1050

Emergency Department Mental Health Assessment

this side to be completed by medical staff

outline of current presentation and precipitating factors

States heavy Bd p auditory hallucinations telling him to hurt himself + others.
Suicidal today.
Called GP + RAH. Apparently RAH called police
Hx of suicidal ideation.

previous mental health problems, self harm, addictions, medication etc

Phones address Dyslexic.
Person DVH
Alcohol excess
Cannabis use

other relevant information; relationships, finances, employment, housing, physical health, childcare etc

Appearance	Behaviour	Speech
Casually dressed	appears agitated	distressed.
Mood	**Thought**	**Insight**
appears (N)	hallucinations	good.

Is the patient a carer for a child or dependent adult? Y/N

Is there a child protection concern? Y/N

Risk assessment

Consider any protective and risk factors

High / Moderate / Low

negative responses in the 4 categories highlighted may allow patients to be categorised as low risk

Suicide Risk Factors (y / n / unknown)			
male gender	(y)	n	u
age <18 or >65	y	(n)	u
depression	(y)	n	u
alcohol or drug use	(y)	n	u
separated, widowed, divorced	(y)	n	u
suicide plan/concealment	(y)	n	u
evidence of psychosis	(y)	n	u
ongoing suicidal intent	(y)	n	u
lack of social support	(y)	n	u
chronic physical illness/pain	(y)	n	u
family history of suicide	y	(n)	u
family concern about risk	y	(n)	u
disengaged/poor compliance	(y)	n	u
unemployed or retired	(y)	n	u
access to lethal means of harm	(y)	n	u
previous violent methods	(y)	n	u
[illegible]	y	(n)	u
[illegible]	y	(n)	u
[illegible]	y	(n)	u
[illegible]	y	(n)	u

Summary and plan for further assessment

referral to liaison psychiatry/duty doctor/CRISIS/CMHT/CAT/addiction services/etc

Summary

Referred HTT

Service referred to | time of referral

for patients awaiting assessment, indicate where they should wait, and who will supervise them; for patients to be transferred, indicate means of travel and anyone who will accompany them; for other outcomes, indicate the follow-up plan and name and relationship of the carers informed of this plan.

print name Maraca

signature

date _____ time _____

NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

Name	
Address	1203893450 12/03/1989 WEIR James
CHI No.	
DoB	

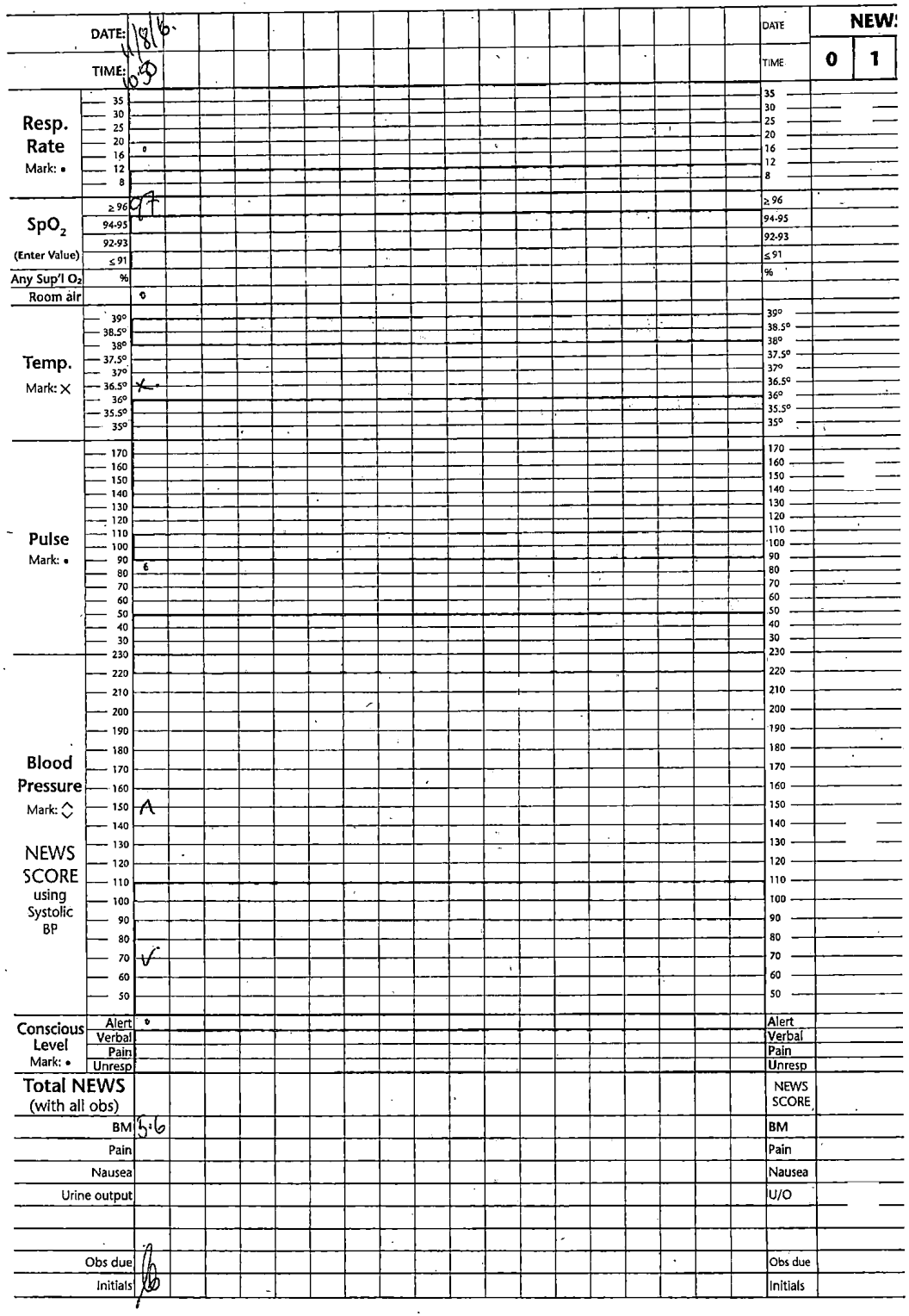
	Date	Ward
Admitted		
Transferred		
Transferred		

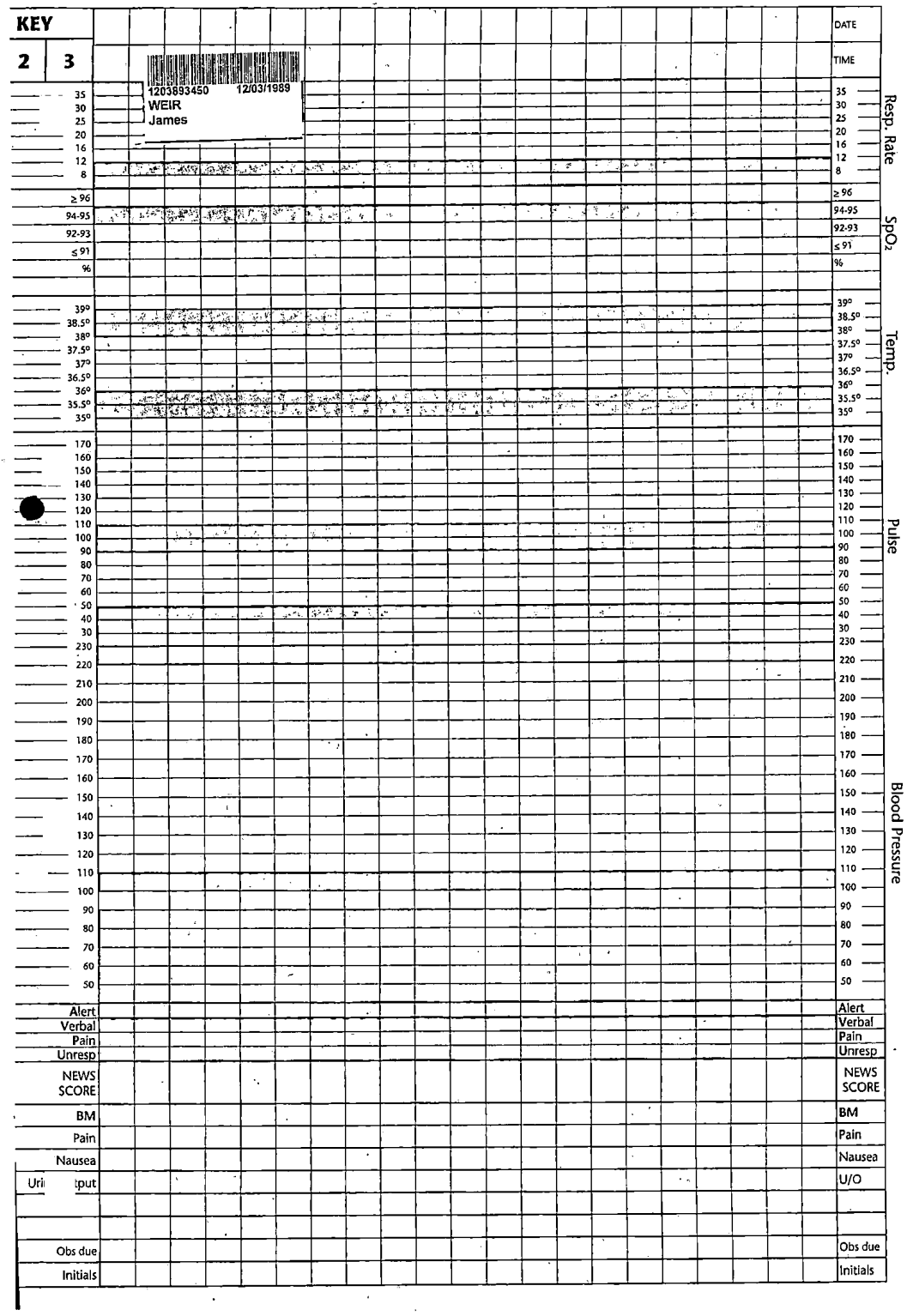
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Oxygen Saturations	≤91	92-93	94-95	≥96			
Any Supplemental Oxygen		Yes		No			
Temperature	≤35.0°		35.1-36.0°	36.1-38.0°	38.1-39°	≥39.1°	
Pulse	≤40		41-50	51-90	91-110	111-130	≥131
Systolic BP	≤90	91-100	101-110	111-219			≥220
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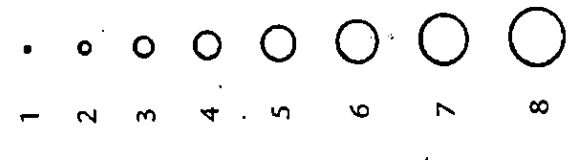
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Aggregate 7 or more	Continuous monitoring of vital signs	• Trained Nurse to assess immediately. • Inform medical team caring for the patient – this should be at least senior medical staff level. • Emergency assessment by a clinical team with core competencies in the assessment of critically ill patients. This team will have critical care competencies and a practitioner/s with advanced airway skills and resuscitation skills. • Consider referral to high dependency or ITU.


DATE: 11/8/16
TIME: 1030
DATE
TIME
NEWS
0
1
Resp. Rate
Mark: •
35
30
25
20
16
12
8
SpO2
(Enter Value)
≥ 96
94-95
92-93
≤ 91
%
97
Any Sup'l O2
Room air
Temp.
Mark: ×
39°
38.5°
38°
37.5°
37°
36.5°
36°
35.5°
35°
Pulse
Mark: •
170
160
150
140
130
120
110
100
90
80
70
60
50
40
30
Blood Pressure
Mark: ◇
230
220
210
200
190
180
170
160
150
140
130
120
110
100
90
80
70
60
50
NEWS SCORE using Systolic BP
Conscious Level
Mark: •
Alert
Verbal
Pain
Unresp
Total NEWS (with all obs)
NEWS SCORE
BM
5.6
Pain
Nausea
Urine output
U/O
Obs due
Initials


KEY
2
3
1203893450 12/03/1989
WEIR
James
DATE
TIME
Resp. Rate
SpO2
Temp.
Pulse
Blood Pressure
Alert
Verbal
Pain
Unresp
NEWS SCORE
BM
Pain
Nausea
U/O
Obs due
Initials

Glasgow Coma Scale

Pupil size (mm)



Neurological Observations

| | | |

NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

CHI: 1203893450

Royal Alexandra Hospital

Total Att: 68

12 Mth Att: 3

Title: **MR**

WEIR **James**

DOB: **12/03/1989** Age: **27y** Sex: **Male**

27D MACDOWALL STREET

Johnstone
Renfrewshire
PA5 8QJ
07474837113

Next of kin: **WEIR, Deborah**
Relationship: **Sister**
0758859964

GP: **EC Renwick**
01505 321733

Attendance Date: **19/07/2016** Arrival Time: **10:12**

Registration Time: **10:12** Date of Incident: **19/07/2016**

Major Incident Desc:

Reason for Attendance: **abdo pains +vomiting blood**

Nursing Assessment

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

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

Presenting Complaint:

Observation Date: **19/07/2016 10:19** Nurse name: **Nurse Diana Clark**

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

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

GCS	
Eyes	
Motor	
Verbal	
Total	

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

Nursing Notes: **2/7 hx vomiting/ abdo pain, coffee ground vomit today.**

Child Assessment Questionnaire

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

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

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

DO NOT WRITE HERE PLEASE

ONCE ONLY PRESCRIPTIONS (including Tetanus Prophylaxis)						
Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Time of Administration	Signature	Given By
19/7/16	DIAZEPAM	20	IV	11.40		
	Ondansetron	4mg	IV	11.40		
	One Lansoprazole	30mg	PO	11.40		

Date	CLINICAL NOTES
	Seen by (Dr) CARALLY1 Time seen 11 - 00

1203893450
WEIR M
James 12/03/1989

27/f
- Alcohol XS
- Binge drinks

P.C. Abdo pain / Vomiting
Started drinking heavily ago yesterday
Cramp abdo pain
Vomiting - dry + coffee grs starry
No melena
No collapse

- O/E Obs (N)

Abdo - / \
| |
\ /

Date	CLINICAL NOTES

Discharge Codes (Please CIRCLE)					Discharge date	
1. Admission	2. Discharge	3. Refer to GP	4. Transfer to other (see below)			
5. Died	6. Refer to OP Clinic (see below)		7. Irregular Discharge	8. D.O.A.	Discharge time	

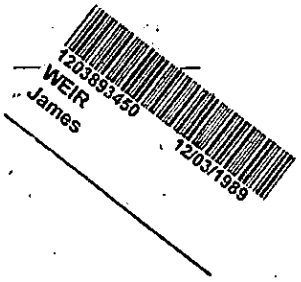
Ward number (if admitted):	Transfer to hospital:	Consultant If admitted):

Follow up	Arranged	Not arranged	To be arranged

Clinic referred to	A&E	Hand injury	Fracture	Pop Check	Medical	Surgical	ENT	Others (specify):

Discharge Prescription Packs

Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Frequency	Signature	Given By



Patient Sample Report

Patient

ID:	1203893450
Last Name:	**WEIR**
First Name:	**JAMES**
Gender/Age:	Male, 27 years
Birth Date:	12/03/1989
Status:	**ACCEPTED**
Analyzed:	19/07/2016 10:57:18
Sample Type:	**Venous**
Operator ID:	CARACHI M

Analyzer

Model:	GEM® *Premier 4000*
Area:	RAHA&E
Name:	A&E
S/N:	09042366

Measured (37.0°C)		
cH	29.1	nmol/L
pCO_2	3.8	kPa
pO_2	5.9	kPa
Na^+	136	mmol/L
K^+	3.0	mmol/L
Cl^-	106	mmol/L
Ca^{++}	1.06	mmol/L
Glu	5.8	mmol/L
Lac	3.1	mmol/L
CO-Oximetry		
tHb	153	g/L
O_2Hb	83.3	%
COHb	1.6	%
MetHb	0.7	%
sO_2	85.3	%
Derived		
BE(B)	3.3	mmol/L
$HCO_3^-(c)$	24.8	mmol/L
Operator Entered		
Temp	37.0	°C

Fluid Balance Chart

1203893450
WEIR M
James 12/03/1989
27D MACDOWALL STREET
Johnstone, Renfrewshire
PA5 8QJ

Hospital: RAH
Ward: AP2
Date: 19/7/16

Reason for Fluid Balance Chart _____

Is patient fluid restricted? Yes ☐ No ☐

If yes how many mls in 24 hours? _____

Fluid balance from previous 24hrs
+/- _____

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

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

Signature: _____ Designation: _____

NHS Greater Glasgow and Clyde

ONLY RECORD INTAKE CONSUMED NOT WHAT IS GIVEN TO PATIENT

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

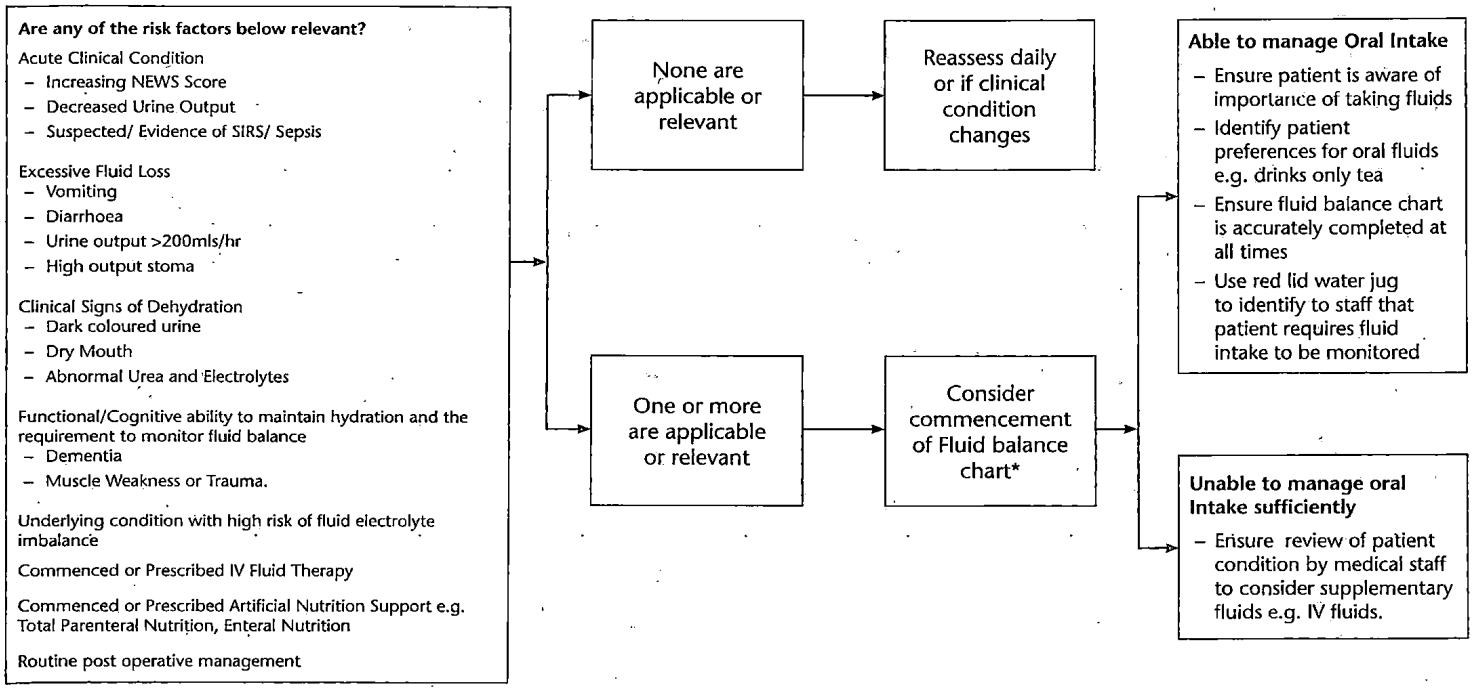
*24 hr Fluid Balance +/-

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

220665

Guide to commencing fluid balance charts

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



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

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

MIS • EDU • 237971-2

Patient name: JAMES WEIR

Date of birth:

CHI No: 1203893450

Affix patient label

ADULT FLUID AND ADDITIVE PRESCRIPTION AND ADMINISTRATION CHART

NHS Greater Glasgow and Clyde

Prescription details - continued									Administration details - continued				
Date	Time	Name of fluid Name of additive	Volume (ml) Dose	Route	Duration(hr) Or Flow rate (ml/hr)	Additional instructions	Prescriber's signature, PRINTED name and designation	*Discontinued by (initial, date and time)	Date	Time	Given by	Checked by	Comments
		N Saline	1L	IV			M. CARLIN		19/7/16	11 40	MJWS		

*Prescriber should sign this box if the fluid/additive is no longer required.

Patient name:.....

Date of birth:.....

CHI No:.....

Affix patient label

ADULT FLUID AND ADDITIVE PRESCRIPTION AND ADMINISTRATION CHART

NHS Greater Glasgow and Clyde

Patient's weight and height

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

Prescription details									Administration details				
Date	Time	Name of fluid Name of additive	Volume (ml) Dose	Route	Duration(hr) Or Flow rate (ml/hr)	Additional instructions	Prescriber's signature, PRINTED name and designation	*Discontinued by (initial, date and time)	Date	Time	Given by	Checked by	Comments

*Prescriber should sign this box if the fluid/additive is no longer required.

Nursing staff guidance on using a drops/min flow rate (if administered by gravity flow)

Calculation:

Rate of flow (drops/min) = $\frac{\text{Volume of fluid (ml) x 20}}{\text{Duration of admin (min)}}$

NB: 1ml = 20 drops (for a standard giving set)

Example:

500ml over 1 hour	167 drops/min
500ml over 4 hours	42 drops/min
500ml over 6 hours	28 drops/min
500ml over 8 hours	21 drops/min

Scottish Ambulance Service Patient Report Form

Incident Number	CR003077779 on 19/07/2016 at 09:34		
Callsign		Incident Type	EMG
Crew1	E0044016 - Driver	Crew3	
Crew2	E0013242 - Attendant	Crew4	

INCIDENT LOG

Incident Location	FLAT D 27 MACDOWALL STREET JOHNSTONE	Incident Postcode	PA5 8QJ
Call Received	09:34 - 19/07/2016	Patient at Hospital	-
Call Passed	09:34 - 19/07/2016	Patient Handover	-
Crew Mobile	09:35 - 19/07/2016	Crew Clear	-
Crew at Scene	09:44 - 19/07/2016	Clear Reason	
Crew Left Scene	09:53 - 19/07/2016		
Receiving Hospital	ROYAL ALEXANDRA - PAISLEY		

DIAGNOSIS

Chief Complaint Code	GPA
Despatch Code	33C03 : Transfer - Significant Haemorrhage or Shock
Diagnostic Code	01A01 : 01A01 - Abdominal Pain

PATIENT DETAILS

Surname	WEIR		
Forename	JAMES		
Middle Initials		Sex	Male
DoB	12/03/1989	Age	27y
Patient Address	27 MCDOWAL STREET JOHNSTONE	Patient Postcode	
Patient Telephone		Ethnicity	
CHI Number	1203893450		

PRIMARY SURVEY

AVPU Assessment	Alert
Catastrophic Haemorrhage	No
Airway Assessment	Clear
Breathing Rate	Normal
Respiratory Rate	16
Skin Colour	Normal
Skin Texture	Sweaty
Capillary Refill Rate	> 2 Secs

VITAL SIGNS

Time	Pulse	Rthm	AVPU	RR	SYS	DIA	PEF	BG	Temp	SpO2	PS	CRT	ECG	Sepsis	GCS	RTS	NEWS	ETCO2	Lactate
09:51	96	Reg	Alert	16	121	87		4.9	35.4			< 2 Secs		2	15	7.8	2		

AMPLE

Previous Medical History	DEPRESSON
Other Disability	
Last Eaten Before Incident	More Than 5 Hours
Events Prior To Incident	PT HAS BEEN VOMITING FOR THE LAST 24 HOURS WITH QUERY BLOOD IN IT AND ABDO PAIN

EYES AND PUPILS

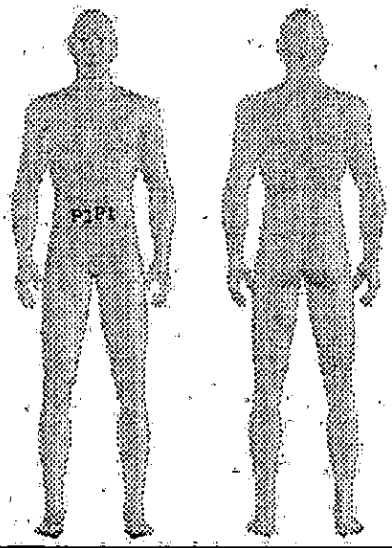
Left Eye		Right Eye	
Left Pupil Size	Normal	Right Pupil Size	Normal
Left Pupil Reaction	Normal	Right Pupil Reaction	Normal
Unequal Reaction To Light			

INJURIES

PAIN	P2	No Pain Relief Provided

1203893450
WEIR
James
M
12/03/1989

1203893450
WEIR, M
James 12/03/1999



SEPSIS

Pulse	RR	SYS	Temp	GCS	BG	Pneumonia	UTI	Other infection	Abdo Pain	Diarrhoea	Abdo distension	Meningitis	Cellulitis	Septic arthritis	Wound infection	Infected indwelling device	No signs of infection
96	16	121	35.4	15	4.9	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO

GCS

Time	Eye Opening	Verbal Response	Motor Response	Total
09:51	Spontaneous	Orientated	Obeys Commands	15

PATIENT SUPPORT

REPORT MANAGEMENT

Report ID	CR003077779-19072016100316		
Software Version	1.0.440	Report Type	Interim

Emergency Department Nursing Documentation

NHS Greater Glasgow and Clyde

Patient Addressograph Label

1203893450 12/03/1989
WEIR
James

Presenting Complaint: Abdo Pain/Vomiting

Date and Time: 19/07/16.

Named Nurse(s): ADen ARD

Patient preparation (Please tick when completed)	Initials: AD	Communication (Please tick when completed)	Initials: AD
Prepare patient for examination and provide blankets if required	☑	Communication Aids (spectacles / hearing aid)	☐
Clothing bagged, labelled and stored under trolley	☑	Relatives present, who?	☐
Name-band (if required) NKDA	☐	Relatives / NOK informed NO-ONE.	☑
		Interpreter required	☐
		Telephone interpretation required	☐

Observations and Investigations (Please tick when completed)		Initials:	
Vital Signs recorded on NEWS chart and NEWS score recorded. Record Pain, blood sugar and neuro obs on NEWS chart if appropriate.	☑	IV cannula (if required)	☐
Peak Flow 1: 2. 3.	☐	Blood samples taken	☐
12 Lead ECG	☐	Urinalysis and Specimen if indicated *Results:* +++ PROTEIN	☑
Cardiac Monitoring	☐		
X-rays performed	☐	HCG specimen if indicated +ve ☐ -ve ☐ Strip Lot no:	☐
Other: please add	☐	Weight:	☐

Screening Tools (Please circle or tick as appropriate)		Initials: AD	
SEPSIS risk? SIRS Criteria 2 or more and suspicion of infection Sepsis 6 protocol initialise and departmental documentation started	Y / (N) Y / (N)	**Preliminary Pressure Ulcer Risk Assessment** The patient can reposition themselves whilst in the department?	(Y) / N
AMT 4 (if >65 years) SCORE	/4	There is **no** reported skin damaged other than presenting trauma?	(Y) / N
At risk of falls? (clinical judgement) (consider alcohol, mobility, age, illness, cognitive impairment etc). *If at risk complete risk assessment*	Y / (N)	The person is fully continent? *If NO to any of the above initiate Waterlow risk assessment (within 4 hrs)*	(Y) / N
Mental Health Triage Assessment	Y / (N)	**Waterlow Score** *If >10 commence Active Care*	☐
Child Protection considered (in line with policy)	Y / (N)	**Active Care** (clinical judgement) (include all trolley patients at risk of pressure ulcers and all trolley patients in department for >4hrs) *Record on Active Care Chart*	☐
FAST	Y / (N)		
GMAWS	Y / N	Pressure damage identified on arrival in ED is documented in clinical notes	☐
Has Swallow test been carried out?	Y / (N)	Grade 3 or 4 Pressure Ulcers are reported on DATIX	☐

Pause for Transfer (Please tick when completed)		Tick when completed	N/A	Notes
	Relatives informed	☐	☐	Information on discussion with relatives
	Cannula	☐	☐	
	Name band	☐	☐	
	AMT4	☐	☐	
	NEWS chart NEWS >7 - Name and Page number of senior doctor caring for patient	☐	Always	
Prescriptions signed	Infusions	☐	☐	
	Drugs	☐	☐	
	Allergies are recorded (e.g. on Kardex)	☐	☐	
	Fluids	☐	☐	
	Two hour plan in place e.g. Fluids, Antibiotics and emergency drugs written up on Kardex	☐	☐	
	GMAWS	☐	☐	
	Belongings (including patient's medications)	☐	Always	Please note here if any other tasks required prior to transfer
	Bed requested, accepted and ward informed	☐	Always	
	Notes: medical notes, GP letter, PRF	☐	Always	
Investigations	CXR reviewed	☐		
	ECG reviewed	☐	☐	Print name
	Bloods sent	☐	☐	
	Bloods reviewed	☐	☐	
	Patient on O_2: cylinder checked	☐	☐	
	Patients requiring analgesia: sufficient	☐	☐	

Patient Addressograph Label

Pause for Discharge (Please tick when completed)	Tick when completed	N/A	Notes
Advice leaflets given	☐	☑	Information on discussion with relatives
Belongings (including patient's medications)	☑	Always	
New medications explained	☐	☑	
Cannula removed	☑	☐	
Relatives aware of discharge	☑	☐	Please note here if any other tasks required prior to discharge
Social/ Support Services required and contacted	☐	☑	
SAS transport required and ref no	☐	☑	Print name E. STEWART
Other means of transport arranged by nurse	☐	☑	

Nursing Notes and Care Plan

Date and Time	19/04/16	Print Name and Signature
10:50	Rento rm (1) awaits GP rev	[illegible]
11 A0	Commenced IV fluids Buscopan 20mg ~~orally~~ IV Lansoprasol 30mg orally IV ondansetron 4mg IV	
	For reassessment	
1325	Discharged Post Review.	


1203893450
WEIR M
James 12/03/1989

Nursing Notes and Care Plan

Date and Time		Print Name and Signature

Emergency Department - Active Care

I have evaluated and deemed that the frequency of care delivery over the next work shift, based on the patient's most critical need should be every:

(Please circle) ½ hour 1hour 2 hours

Signed ..... Name .....

USE FOLLOWING CODE:

O = Off the ward V = Variant S = Sleeping I = Independent NT = No Thanks

Patient Addressograph Label

			Time							
	1.	**PAIN:** Assess and address If in pain inform registered nurse Y/ N or N/A								
S	2.	**SKIN INSPECTION** Pressure areas checked: Y / N / I (independent)								
		Redness (R) / Discolouration (D) / Pressure Ulcer (PU) / Intact (INT)								
K	3.	**KEEP MOVING:** Have you moved or walked Y / N / I (independent)								
		Bed Right side (30° tilt) – R Left Side (30° tilt) – L Back– B								
		Chair Assist to walk, stand or tilt (W /ST/ T)								
I	4.	**ELIMINATION:** Do you need the toilet? I = Independent A = Assistance given IC = patient incontinent of urine/faeces								
N	5.	**FOOD, FLUIDS AND NUTRITION:** Is the patient nil by mouth? Y / N (consider mouth care)								
		Encourage the patient to drink? **(If appropriate)** Y / N / N/A								
		Food, snack or supplement taken? **(if appropriate)** Y / N / N/A								
	6.	**ENVIRONMENT:** Is the patient able to call for assistance? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position? Y / N								
	7.	**INFORMATION:** Ask: Is there anything else I can help you with? Inform patient of the time of return. Y / N								
	8.	**ESCALATION:** Escalate any issues to the Registered Nurse? Y / N/A								
		Nurse Initials								

USE FOLLOWING CODE	Specialist Pressure Redistributing equipment	Variations			
V = Variant I = Independent NT = No thanks	☐ Repose Mattress ☐ Moving and handling aids ☐ Other:	Time	No.	Variation	Signed

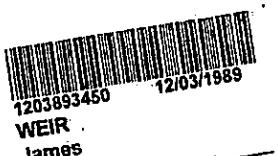
Waterlow Pressure Area Risk Assessment

Build/Weight		Skin Type/Visual Risk Areas		Sex/Age		Special Risks – Tissue Malnutrition	
Average (BMI 20-24.9)	0	Healthy	0	Male	1	Multiple organ failure/ Terminal cachexia	8
Above Average (BMI 25-29.9)	1	Tissue Paper (thin/fragile)	1	Female	2		
Obese (BMI > 30)	2	Dry (appears flaky)	1	14-49	1	Single organ failure	5
Below Average (BMI < 20)	3	Oedematous (puffy)	1	50-64	2	Peripheral Vascular Disease	5
Continence		Clammy /pyrexia	1	65-74	3	Anaemia = Hb < 8	2
Complete/Catheterised	0	Discoloured (brusing/mottled)	2	75-80	4	Smoking	1
Incontinent urine	1			81+	5	Neurological Deficit	
Incontinent faeces	2	Broken (established ulcer)	3	**Nutritional Element**		Diabetes/MS/CVA Motor or sensory paraplegia (Max 6)	4-6
Doubly Incontinent (urine and faeces)	3	**Mobility**		Unplanned weight loss in past 3-6 months < 5% Score 0 5-10% Score 1 > 10% Score 2			
		Fully mobile	0				
Special Risks – Surgery/Trauma		Restless/Fidgety	1			**Special Risks - Medication**	
On table > 6 hours	8	Apathetic (sedated/depressed/ reluctant to move)	2			Cytotoxic, anti-inflammatory, long term/high dose steroids (Max 4)	4
Orthopaedic / below waist/Spinal (up to 48 hrs post-op)	5			BMI > 20 Score 0 BMI 18.5-20 Score 1 BMI < 18.5 Score 2			
On table > 2 hours (up to 48 hrs post op)	5	Bed bound (unconscious/unable to change position/traction)	4			**Risk Score** 10+ = 'At risk' 15+ = 'High Risk' 20+ = 'Very High Risk'	
		Chair Bound	5	Patient acutely ill or no nutritional intake > 5 days	2		
Patient's Initial Waterlow Score =		If Score ≥10 Complete the Adapted Waterlow Pressure Area Risk Assessment Chart					

NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

Name
Address



CHI No.
DoB

	Date	Ward
Admitted	19/7/16	ED
Transferred		
Transferred		

Physiological Parameter	NEWS – NHS Early Warning Score						
	3	2	1	0	1	2	3
Respiration Rate	≤8		9-11	12-20		21-24	≥25
Oxygen Saturations	≤91	92-93	94-95	≥96			
Any Supplemental Oxygen		Yes		No			
Temperature	≤35.0°		35.1-36.0°	36.1-38.0°	38.1-39°	≥39.1°	
Pulse	≤40		41-50	51-90	91-110	111-130	≥131
Systolic BP	≤90	91-100	101-110	111-219			≥220
Conscious Level				A			V, P or U

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

See NEWS Actions Reference Tool for local escalation policy

NEWS Score	Frequency of Monitoring	Clinical Response
0	Minimum 12 hourly	• Continue routine NEWS monitoring with every set of observations.
Aggregate 1- 4	Minimum 4 hourly	• Inform trained nurse. • Trained Nurse assessment: - Assess the patient - Review frequency of monitoring required - Assess need for escalation of clinical care and direct as appropriate.
Aggregate 5 or more or 3 in one parameter	Increased frequency to a minimum of 1 hourly	• Trained Nurse assessment. • Inform medical team caring for the patient. • Urgent assessment by a medical / surgical / nursing team with core competencies to assess acutely ill patients. • Consider level of monitoring required in relation to clinical care.
Aggregate 7 or more	Continuous monitoring of vital signs	• Trained Nurse to assess immediately. • Inform medical team caring for the patient – this should be at least senior medical staff level. • Emergency assessment by a clinical team with core competencies in the assessment of critically ill patients. This team will have critical care competencies and a practitioner/s with advanced airway skills and resuscitation skills. • Consider referral to high dependency or ITU.

| | | |

KEY

2 | 3

1203893450
WEIR M.
James 12/03/1989
27D MACDOWALL STREET
Johnstone, Renfrewshire.
PA5 8QJ

DATE

TIME

Resp. Rate: 35 30 25 20 16 12 8

SpO2: ≥ 96 | 94-95 | 92-93 | ≤ 91 | %

Temp.: 39° 38.5° 38° 37.5° 37° 36.5° 36° 35.5° 35°

Pulse: 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30

Blood Pressure: 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50

Alert
Verbal
Pain
Unresp

NEWS SCORE

BM

Pain

Nausea

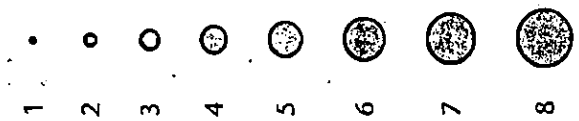
Urine output

Obs due

Initials

Glasgow Coma Scale

Pupil size (mm)



Neurological Observations

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

Pain Score

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

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

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

Management Plan and Patient Exclusions

Date and Time	Notes	Signed

~~PEWS~~ CWOA

NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

Affix Label

CHI: 1203893450

Royal Alexandra Hospital

Total Att: **67**

12 Mth Att: **2**

Title: **MR**

WEIR **James**

DOB: **12/03/1989** Age: **27y** Sex: **Male**

27D MACDOWALL STREET

Johnstone
Renfrewshire
PA5 8QJ
07474837113

Next of kin: **WEIR, Deborah**
Relationship: **Sister**
0758859964

GP: **EC Renwick**
01505 321733

Attendance Date: **02/06/2016** Arrival Time: **12:08**

Registration Time: **12:08** Date of Incident: **02/06/2016**

Major Incident Desc:

Reason for Attendance: **chest pain (biba)**

Affix Label

Nursing Assessment

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

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

Presenting Complaint:

Observation Date: **02/06/2016 12:14** Nurse name: **Nurse Michelle Mccord**

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

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

Visual Acuity	
Left	
Right	
Corrected?	

GCS	
Eyes	
Motor	
Verbal	
Total	

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

Nursing Notes: **chest pain nauseated smoked cannabis this morning, given maxalon by crew**

97607

Child Assessment Questionnaire

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

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

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

DO NOT WRITE HERE PLEASE

ONCE ONLY PRESCRIPTIONS (including Tetanus Prophylaxis)						
Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Time of Administration	Signature	Given By
2/6/16	PARACETAMOL	1g	PO	13:50	[illegible]	[illegible]
2/6/16	RANITIDINE	150mg	PO	13:50	[illegible]	[illegible]
2/6/16	~~ONDANSETRON~~	~~4mg~~	~~PO~~		[illegible]	

WGIR 1203893450

Date	CLINICAL NOTES
2/6/16	Seen by (Dr) MCGOUGH. Time seen 1810.

27♂

PC/ Chest pain and nausea

Been feeling unwell last 2-3 days with nausea, reduced appetite, vomiting and intermittent chest pains.
Vomited ~ 8 times, no blood.
Chest pain varying 15min - 2hrs, no exacerbating or relieving factors feels like a heaviness. radiates to upper abdo.

This morning felt well, was at court whilst in front of judge felt unwell again nauseas with chest pain again.
vomited x 3.
Had intermittent frontal headache, no visual disturbance / LOC / seizure / rash / photophobia.

PMHx:- Anxiety & depression. DHx:- sertraline
on ECG pericarditis. NKDA.

SHx:- smokes 20cpd stopped 4 days ago, alcohol on occasion, smokes 1.6g cannabis / day stopped 4 days ago. No other drugs

Obs:- RR16 Sats 98% Temp 36.4 HR100 BP 120/70

O/E:- looks well, yawning several times appears hydrated
Chest clear

HS I+II+0

Abdo soft BS nve
mild tenderness epigastric

Date	CLINICAL NOTES
	ECG:- N/ischaemic, early repolarization V3-V5. VBG:- Ht 39·1 pCO_2 5·7 Na 137 Kt 3·7 Gluc 5·6 Lact 0·8 HCO_3- 27·3. Imp:- ? Symptoms related to stopping cannabis abruptly. Plan:- IV access and bloods. - whilst waiting analgesia and ranitidine - CXR CW CXR nil focal Bloods Hb 147 . U&Es and LFTs (N) WCC 13·7 . CRP <1 Amylase 104 Troponin <1 Discharged, smoking cessation - advised to return if deterioration CW

Discharge Codes (Please CIRCLE)					Discharge date	
1. Admission	2. Discharge	3. Refer to GP	4. Transfer to other (see below)			
5. Died	6. Refer to OP Clinic (see below)		7. Irregular Discharge	8. D.O.A.	Discharge time	

Ward number (if admitted):	Transfer to hospital:	Consultant If admitted):

Follow up	Arranged			Not arranged			To be arranged	
Clinic referred to	A&E	Hand injury	Fracture	Pop Check	Medical	Surgical	ENT	Others (specify):

Discharge Prescription Packs

Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Frequency	Signature	Given By

Designed by Medical Illustration Services ref 243836

Emergency Department Nursing Documentation

NHS Greater Glasgow and Clyde

Patient Addressograph Label

1203893450 12/03/1989
WEIR
James

Presenting Complaint: Chest pain

Date and Time: 2/6/16 12:20

Named Nurse(s): ABOTD

Patient preparation (Please tick when completed)	Initials: CW	Communication (Please tick when completed)	Initials: CW
Prepare patient for examination and provide blankets if required	✓	Communication Aids (spectacles / hearing aid) None	✓
Clothing bagged, labelled and stored under trolley	✓	Relatives present, who? Alone	✓
Name-band (if required) NKA	✓	Relatives / NOK informed Alone	✓
		Interpreter required N/A	☐
		Telephone interpretation required N/A	☐

Observations and Investigations (Please tick when completed)			Initials:
Vital Signs recorded on NEWS chart and NEWS score recorded. Record Pain, blood sugar and neuro obs on NEWS chart if appropriate.	✓	IV cannula (if required) ✓ hand / green	✓
Peak Flow 1. 2. 3.	☐	Blood samples taken	☐
12 Lead ECG	✓	Urinalysis and Specimen if indicated	☐
Cardiac Monitoring	✓	*Results:*	
X-rays performed	☐	HCG specimen if indicated +ve ☐ -ve ☐ Strip Lot no: N/A	☐
Other: please add	☐	Weight:	☐

Screening Tools (Please circle or tick as appropriate)			Initials: CW
SEPSIS risk? SIRS Criteria 2 or more and suspicion of infection Sepsis 6 protocol initialise and departmental documentation started	Y (N) Y (N)	Preliminary Pressure Ulcer Risk Assessment The patient can reposition themselves whilst in the department?	(Y) N
AMT 4 (if >65 years) SCORE	4 /4	There is **no** reported skin damaged other than presenting trauma?	(Y) N
At risk of falls? (clinical judgement) (consider alcohol, mobility, age, illness, cognitive impairment etc). *If at risk complete risk assessment*	Y / (N)	The person is fully continent? *If NO to any of the above initiate Waterlow risk assessment (within 4 hrs)*	(Y) N
Mental Health Triage Assessment	Y / (N)	Waterlow Score *If >10 commence Active Care*	☐
Child Protection considered (in line with policy)	Y / (N)	Active Care (clinical judgement) (include all trolley patients at risk of pressure ulcers and all trolley patients in department for >4hrs) *Record on Active Care Chart*	✓
FAST	Y (N)		
GMAWS	Y (N)	Pressure damage identified on arrival in ED is documented in clinical notes	☐
Has Swallow test been carried out?	Y (N)	Grade 3 or 4 Pressure Ulcers are reported on DATIX	☐

Pause for Transfer (Please tick when completed)		Tick when completed	N/A	Notes
	Relatives informed	☐	☐	Information on discussion with relatives
	Cannula	☐	☐	
	Name band	☐	☐	
	AMT4	☐	☐	
	NEWS chart NEWS >7 - Name and Page number of senior doctor caring for patient	☐	Always	
Prescriptions signed	Infusions	☐	☐	
	Drugs	☐	☐	
	Allergies are recorded (e.g. on Kardex)	☐	☐	
	Fluids	☐	☐	
	Two hour plan in place e.g. Fluids, Antibiotics and emergency drugs written up on Kardex	☐	☐	
	GMAWS	☐	☐	
	Belongings (including patient's medications)	☐	Always	Please note here if any other tasks required prior to transfer
	Bed requested, accepted and ward informed	☐	Always	
	Notes: medical notes, GP letter, PRF	☐	Always	
Investigations	CXR reviewed	☐		
	ECG reviewed	☐	☐	Print name
	Bloods sent	☐	☐	
	Bloods reviewed	☐	☐	
	Patient on O_2: cylinder checked	☐	☐	
	Patients requiring analgesia: sufficient	☐	☐	

PECOS 110452 MIS 262617-A

Patient Addressograph Label

1203893450 12/03/1989
WEIR
James

Pause for Discharge (Please tick when completed)	Tick when completed	N/A	Notes
Advice leaflets given	☐	☐	Information on discussion with relatives
Belongings (including patient's medications)	☐	Always	
New medications explained	☐	☐	
Cannula removed	☐	☐	
Relatives aware of discharge	☐	☐	Please note here if any other tasks required prior to discharge
Social/ Support Services required and contacted	☐	☐	
SAS transport required and ref no	☐	☐	Print name
Other means of transport arranged by nurse	☐	☐	

Nursing Notes and Care Plan

Date and Time		Print Name and Signature
	Patient in room & ready for examination.	
2.6.16	12 lead ECG completed.	S/N
12:35.	3 lead heart monitor in situ	in NOTARP

Patient Addressograph Label

1203893450

WGIR

Nursing Notes and Care Plan

Date and Time		Print Name and Signature

Emergency Department - Active Care

1203893450 12/03/1989.
Pa WEIR
James
h Label

I have evaluated and deemed that the frequency of care delivery over the next work shift, based on the patient's most critical need should be every:

(Please circle) ½ hour 1hour ~~2 hours~~ 4 hours

Signed ..... Name .....

USE FOLLOWING CODE:

O = Off the ward V = Variant S = Sleeping I = Independent NT = No Thanks

			Time						
			12:35						
	1.	**PAIN: Assess and address** If in pain inform registered nurse **Y/ N or N/A**	Y						
S	2.	**SKIN INSPECTION** Pressure areas checked: **Y / N / I (independent)**	Y/I						
		Redness (R)/ Discolouration (D) / Pressure Ulcer (PU) / Intact (INT)	INT						
K	3.	**KEEP MOVING:** Have you moved or walked **Y / N / I (independent)**	Y						
		Bed Right side (30° tilt) – R Left Side (30° tilt) – L Back– B	B						
		Chair Assist to walk, stand or tilt (W /ST/ T)	–						
I	4.	**ELIMINATION:** Do you need the toilet? I = Independent A = Assistance given IC = patient incontinent of urine/faeces	I						
N	5.	**FOOD, FLUIDS AND NUTRITION:** Is the patient nil by mouth? **Y / N** (consider mouth care)	N						
		Encourage the patient to drink? **(If appropriate) Y / N / N/A**	Y						
		Food, snack or supplement taken? **(if appropriate) Y / N / N/A**	N						
	6.	**ENVIRONMENT:** Is the patient able to call for assistance? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position? **Y / N**	Y						
	7.	**INFORMATION: Ask:** Is there anything else I can help you with? Inform patient of the time of return. **Y / N**	NT						
	8.	**ESCALATION:** Escalate any issues to the Registered Nurse? **Y / N/A**	N/A						
		Nurse Initials	W						

USE FOLLOWING CODE	Specialist Pressure Redistributing equipment	Variations			
V = Variant I = Independent NT = No thanks	☐ Repose Mattress ☐ Moving and handling aids ☐ Other:	Time	No.	Variation	Signed

Waterlow Pressure Area Risk Assessment

Build/Weight		Skin Type/Visual Risk Areas		Sex/Age		Special Risks – Tissue Malnutrition	
Average (BMI 20-24.9)	0	Healthy	0	Male	1	Multiple organ failure/ Terminal cachexia	8
Above Average (BMI 25-29.9)	1	Tissue Paper (thin/fragile)	1	Female	2		
Obese (BMI > 30)	2	Dry (appears flaky)	1	14-49	1	Single organ failure	5
Below Average (BMI < 20)	3	Oedematous (puffy)	1	50-64	2	Peripheral Vascular Disease	5
Continence		Clammy /pyrexia	1	65-74	3	Anaemia = Hb < 8	2
Complete/Catheterised	0	Discoloured (brusing/mottled)	2	75-80	4	Smoking	1
Incontinent urine	1			81+	5	**Neurological Deficit**	
Incontinent faeces	2	Broken (established ulcer)	3	**Nutritional Element**		Diabetes/MS/CVA Motor or sensory paraplegia (Max 6)	4-6
Doubly incontinent (urine and faeces)	3	**Mobility**		Unplanned weight loss in past 3-6 months < 5% Score 0 5-10% Score 1 > 10% Score 2			
		Fully mobile	0				
Special Risks – Surgery/Trauma		Restless/Fidgety	1			**Special Risks - Medication**	
On table > 6 hours	8	Apathetic (sedated/depressed/ reluctant to move)	2			Cytotoxic, anti-inflammatory, long term/high dose steroids (Max 4)	4
Orthopaedic / below waist/Spinal (up to 48 hrs post-op)	5			BMI > 20 Score 0 BMI 18.5-20 Score 1 BMI < 18.5 Score 2			
On table > 2 hours (up to 48 hrs post op)	5	Bed bound (unconscious/unable to change position/traction)	4			Risk Score 10+= 'At risk' 15+ = 'High Risk' 20+ = 'Very High Risk'	
		Chair Bound	5	Patient acutely ill or no nutritional intake > 5 days	2		

Patient's Initial Waterlow Score = If Score ≥10 Complete the Adapted Waterlow Pressure Area Risk Assessment Chart

NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

Name
Address



CHI No.
DoB

	Date	Ward
Admitted		
Transferred		
Transferred		

Physiological Parameter	NEWS – NHS Early Warning Score						
	3	2	1	0	1	2	3
Respiration Rate	≤8		9-11	12-20		21-24	≥25
Oxygen Saturations	≤91	92-93	94-95	≥96			
Any Supplemental Oxygen		Yes		No			
Temperature	≤35.0°		35.1-36.0°	36.1-38.0°	38.1-39°	≥39.1°	
Pulse	≤40		41-50	51-90	91-110	111-130	≥131
Systolic BP	≤90	91-100	101-110	111-219			≥220
Conscious Level				A			V, P or U

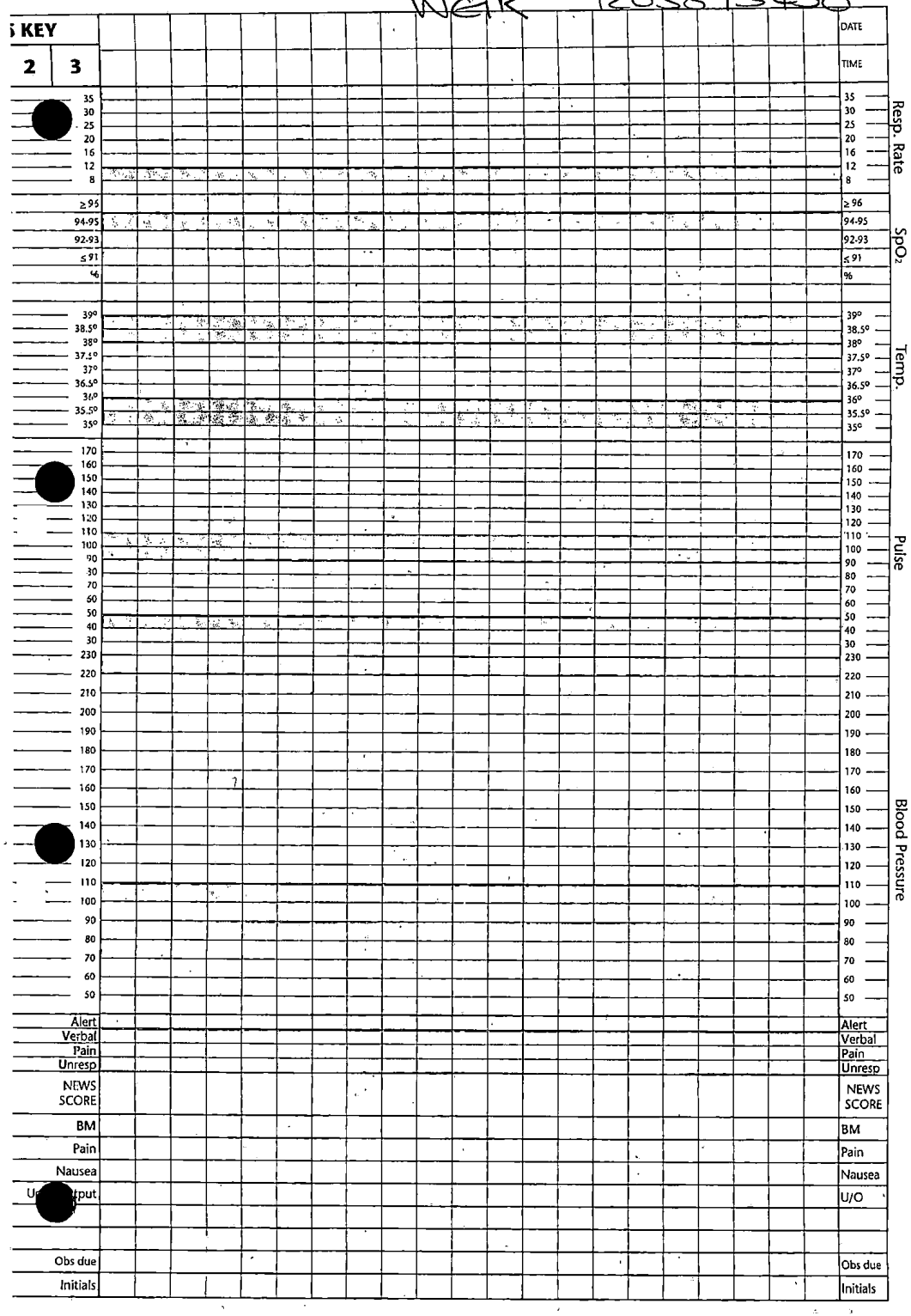
NEWS should not replace sound clinical judgement. Any concerns regarding the patient's condition should be appropriately escalated and documented in the Nursing Notes.

See NEWS Actions Reference Tool for local escalation policy

NEWS Score	Frequency of Monitoring	Clinical Response
0	Minimum 12 hourly	• Continue routine NEWS monitoring with every set of observations.
Aggregate 1-4	Minimum 4 hourly	• Inform trained nurse. • Trained Nurse assessment: - Assess the patient - Review frequency of monitoring required - Assess need for escalation of clinical care and direct as appropriate.
Aggregate 5 or more or 3 in one parameter	Increased frequency to a minimum of 1 hourly	• Trained Nurse assessment. • Inform medical team caring for the patient. • Urgent assessment by a medical / surgical / nursing team with core competencies to assess acutely ill patients. • Consider level of monitoring required in relation to clinical care.
Aggregate 7 or more	Continuous monitoring of vital signs	• Trained Nurse to assess immediately. • Inform medical team caring for the patient – this should be at least senior medical staff level. • Emergency assessment by a clinical team with core competencies in the assessment of critically ill patients. This team will have critical care competencies and a practitioner/s with advanced airway skills and resuscitation skills. • Consider referral to high dependency or ITU.

| | | |

WGR 1203875450



Neurological Observations

| | | |

WEIR, JAMES ID: 1203893450 2-Jun-2016 :25 RAH

12-Mar-1989
Male Caucasian

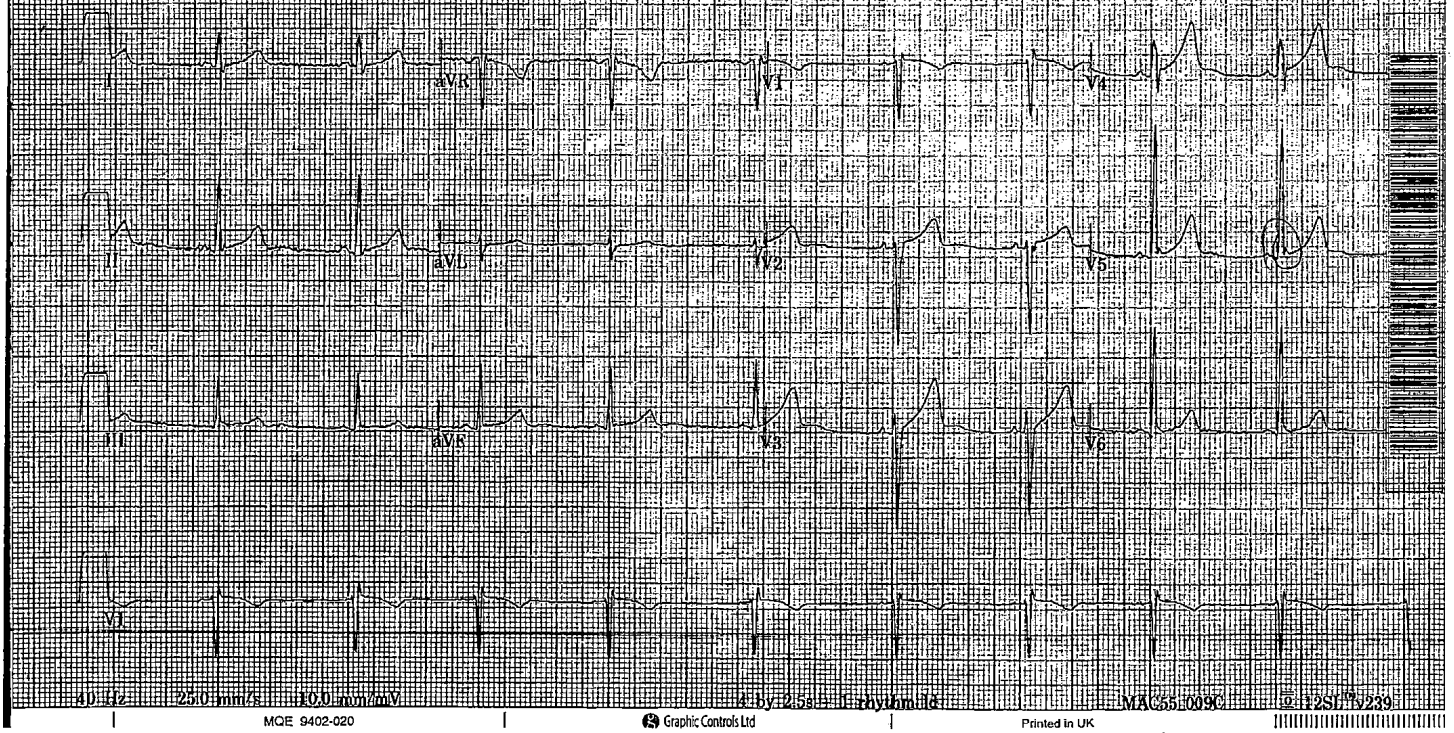
Room:
Loc: 800 Opt:

Technician:
Test-ind:

Vent. rate 59 bpm
PR interval 114 ms
QRS duration 90 ms
QT/QTc 430/425 ms
P-R-T axes 43 73 58

Sinus bradycardia
RSR' or QR pattern in V1 suggests right ventricular conduction delay
ST elevation, probably due to early repolarization

Referred by: Unconfirmed



40 Hz 25.0 mm/s 10.0 mm/mV 4 by 2.5 s + 1 rhythm lead MA55 009C 12SL v239

MQE 9402-020 Graphic Controls Ltd Printed in UK

WEIR
1203893450

Scottish Ambulance Service Patient Report Form			
Incident Number	CR002974298 on 02/06/2016 at 11:11		
Callsign		Incident Type	EMG
Crew1	E000555X - Driver	Crew3	
Crew2	E0039608 - Attendant	Crew4	
INCIDENT LOG			
Incident Location	O/S GREENLAW IND ESTATE RAINBOW TURTLE WALLNEUK ROAD PAISLEY	Incident Postcode	PA3 4BT
Call Received	11:11 - 02/06/2016	Patient at Hospital	11:59 - 02/06/2016
Call Passed	11:12 - 02/06/2016	Patient Handover	-
Crew Mobile	11:13 - 02/06/2016	Crew Clear	-
Crew at Scene	11:19 - 02/06/2016	Clear Reason	
Crew Left Scene	11:49 - 02/06/2016		
Receiving Hospital	ROYAL ALEXANDRA - PAISLEY		
DIAGNOSIS			
Chief Complaint Code	10		
Despatch Code	10D05 : Nausea or Vomiting with Chest Pains		
Diagnostic Code	10D05 : 10D05 - Nausea or Vomiting with Chest Pains		
PATIENT DETAILS			
Surname	WEIR		
Forename	JAMES		
Middle Initials		Sex	Male
DoB	12/03/1989	Age	27 years 2 months 21 days
Patient Address	27 MACDOWALL STREET, JOHNSTONE.	Patient Postcode	PA5 8QJ
Patient Telephone	07804985347	Ethnicity	A1 - White Scottish
PATIENT CONSENT			
Mental Capacity Assessed	Deemed To Have Capacity		
Level of Consent	Advice Given To Patient, Risks Of Condition Explained, Treatment Benefits Explained		
PRIMARY SURVEY			
AVPU Assessment		Alert	
Catastrophic Haemorrhage		No	
Airway Assessment		Clear	
Breathing Rate		Fast	
Respiratory Rate		26	
Pulse		Normal	
Most Peripheral Palpable Pulse Found		Radial	
Skin Colour		Normal	
Skin Texture		Sweaty	
Capillary Refill Rate		< 2 Secs	
CSI Assessment		None	
Circulation Treatment			
IV Cannula			
PVC Record Completed	YES	Aseptic Techniques Followed	YES
Time of Cannulation	11:37		

VITAL SIGNS

Time	Pulse	Rthm	AVPU	RR	SYS	DIA	PEF	BG	Temp	SpO2	PS	CRT	ECG	Sepsis	GCS	RTS	NEWS	ETCO2	Lactate
11:21	84	Reg	Alert	26	109	92		5.2	36.4	96	6	< 2 Secs		1	15	7.8	4		
11:33	70	Reg	Alert	22	113	90							Normal sinus rhythm	1	15	7.8	2		

AMPLE	
Allergy Type	None
Previous Medication	SERTRALINE
Previous Medical History	DEPRESSION.
Last Eaten Before Incident	4 Hours
Events Prior To Incident	999 CALL TO A27 Y.O.M PT EXP 48 HR OF INTERMITTENT CENTRAL CHEST PAIN RADIATING TO L/ARM AND BACK. TODAY PAIN GOT WORSE,6/10 DESC AS SHARP WITH PT NAUSEUS AND CONTINUAL VOMITING. PAIN WORSE ON PALPATION,INHALATION. PT SMOKES CANABIS.

EYES AND PUPILS			
Left Eye		Right Eye	
Left Pupil Size	Normal	Right Pupil Size	Normal
Left Pupil Reaction	Normal	Right Pupil Reaction	Normal
Unequal Reaction To Light			

MEDICINES

Drug	Time	Dosage	Route	Crew No	Batch/Expiry	Pain Before	Pain After
Metoclopramide	11:39	10 mg	IV	E0039608	509063		

CHEST PAIN	
Patient Weight In Kg	65
Symptoms	Chest Pain, Nausea, Sweaty

WGR

1203893450

Time Of Onset		Physical Activity	No Physical Activity
Activity at time	48 HR HX OF CHEST PAIN.		
Pain Location	Central, Radiates to arms, Radiates to back		
Pain Character	Sharp		
Other ECG Details	NSR		

PATIENT HANDOVER

Patient Mobility On Arrival	Seated	On Scene Removal	Stretcher
Patient Transportation	Lying	Care Delivery At Hospital	Trolley
Time Of Patient Handover	12:02		

SEPSIS

Pulse	RR	SYS	Temp	GCS	BG	Pneumonia	UTI	Other infection	Abdo Pain	Diarrhoea	Abdo distension	Meningitis	Cellulitis	Septic arthritis	Wound infection	Infected indwelling device	No signs of infection
84	26	109	36.4	15	5.2	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO
70	22	113		15		NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO

GCS

Time	Eye Opening	Verbal Response	Motor Response	Total
11:21	Spontaneous	Orientated	Obeys Commands	15
11:33	Spontaneous	Orientated	Obeys Commands	15

PATIENT SUPPORT

GP Name	DR RENNWICK	GP Practice	QUARRYSIDE MEDICAL PRACTICE.
Surgery Address		Surgery Postcode	
Next of Kin	LYNN COLLUM	Next of Kin Telephone	
Next of Kin Address			

REPORT MANAGEMENT

Report ID	CR002974298-02062016120015		
Software Version	1.0.413	Report Type	Interim

7A

PWA

NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

Affix Label

CHI: 1203893450

Royal Alexandra Hospital

Total Att: 66

12 Mth Att: 7

Title: MR

WEIR **James**

DOB: **12/03/1989** Age: **26y** Sex: **Male**

27D MACDOWALL STREET

Johnstone
Renfrewshire
PA5 8QJ
07474837113

Next of kin: **WEIR, Deborah**
Relationship: **Sister**
0758859964

GP: **EC Renwick**
01505 321733

Attendance Date: **03/11/2015** Arrival Time: **19:57**

Registration Time: **19:57** Date of Incident: **03/11/2015**

Major Incident Desc:

Reason for Attendance: **right hand injury**

Affix Label

Nursing Assessment

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

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

Presenting Complaint:

Observation Date: **03/11/2015 20:01** Nurse name: **Nurse Esther Iheagwaram**

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

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

Visual Acuity	
Left	
Right	
Corrected?	

GCS	
Eyes	
Motor	
Verbal	
Total	

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

Nursing Notes: **punched a wall last week**

Child Assessment Questionnaire

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

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

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

DO NOT WRITE HERE PLEASE

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

Date	CLINICAL NOTES
	Seen by (Dr) [illegible] Time seen 2150
3/11/15	26 ♂ - (R) hand punch injury (RHD)
HPC	Patient punched a wall 1/52 ago. Still painful. No paraesthesia

1203893450 12/03/1989
WEIR
James

O/E - RIGHT HAND

No obvious bruising, deformity. No swelling or rotational deformity.

Median, Radial, Ulnar } motor + sensory intact.

Tender (minimally) over base of 5th MC.

No crepitus

Xray: No acute bony injury (R) hand seen.

Plan - Analgesia
- Review.

[illegible]

[illegible]

Date	CLINICAL NOTES

Discharge Codes (Please CIRCLE)					Discharge date	
1. Admission	2. Discharge	3. Refer to GP	4. Transfer to other (see below)			
5. Died	6. Refer to OP Clinic (see below)		7. Irregular Discharge	8. D.O.A.	Discharge time	

Ward number (if admitted):	Transfer to hospital:	Consultant If admitted):

Follow up	Arranged			Not arranged			To be arranged	
Clinic referred to	A&E	Hand injury	Fracture	Pop Check	Medical	Surgical	ENT	Others (specify):

Discharge Prescription Packs

Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Frequency	Signature	Given By

Designed by Medical Illustration Services ref 243836

FE

MVA

NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

CHI: 1203893450

Royal Alexandra Hospital

Total Att: **64**

12 Mth Att: **13**

Title: **MR**

WEIR **James**

DOB: **12/03/1989** Age: **26y** Sex: **Male**

27D MACDOWALL STREET

Johnstone
Renfrewshire
PA5 8QJ
07468282574

Next of kin: **GUTHERIE, Mary**
Relationship: **Mother**
01418480859

GP: **EC Renwick**
01505 321733

Attendance Date: **18/05/2015** Arrival Time: **10:06**

Registration Time: **10:06** Date of Incident: **18/05/2015**

Major Incident Desc:

Reason for Attendance: **lower back injury**

Nursing Assessment

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

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

Presenting Complaint:

Observation Date: **18/05/2015 10:24** Nurse name: **Nurse Roderick Harkin**

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

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

GCS	
Eyes	
Motor	
Verbal	
Total	

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

Nursing Notes: **fell backwards 2 days ago. c/o , lower back pain**

Child Assessment Questionnaire

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

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

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

DO NOT WRITE HERE PLEASE

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

Date	CLINICAL NOTES
	Seen by (Dr) McMahon Cons EM Time seen

1203893450 12/03/1989
WEIR
James

26 o♂

slipped + fell hill walking
direct landing on coccyx
pain - esp on sitting
no neuro symptoms

O/E well
thin
Ⓝ alignment
tender coccyx °swelling
SIJ non tender
hips non tender
FROM
L spine NBT
FROM spine
°neurology

Imp coccyx injury
imaging will not change Rx

Plan Ⓜ ± analgesia + advice

McMahon

Date	CLINICAL NOTES

Discharge Codes (Please CIRCLE)					Discharge date	
1. Admission	2. Discharge	3. Refer to GP	4. Transfer to other (see below)			
5. Died	6. Refer to OP Clinic (see below)		7. Irregular Discharge	8. D.O.A.	Discharge time	

Ward number (if admitted):	Transfer to hospital:	Consultant If admitted):

Follow up	Arranged			Not arranged			To be arranged	
Clinic referred to	A&E	Hand injury	Fracture	Pop Check	Medical	Surgical	ENT	Others (specify):

Discharge Prescription Packs

Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Frequency	Signature	Given By
18/5	CO-CODAMOL 30/500	2 TAB	PO	6°		
	DICLOFENAC	50mg	PO	8°		

Designed by Medical Illustration Services ref 243836

NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

Name	
Address	
CHI No.	1203893450 12/03/1989 WEIR James
DoB	

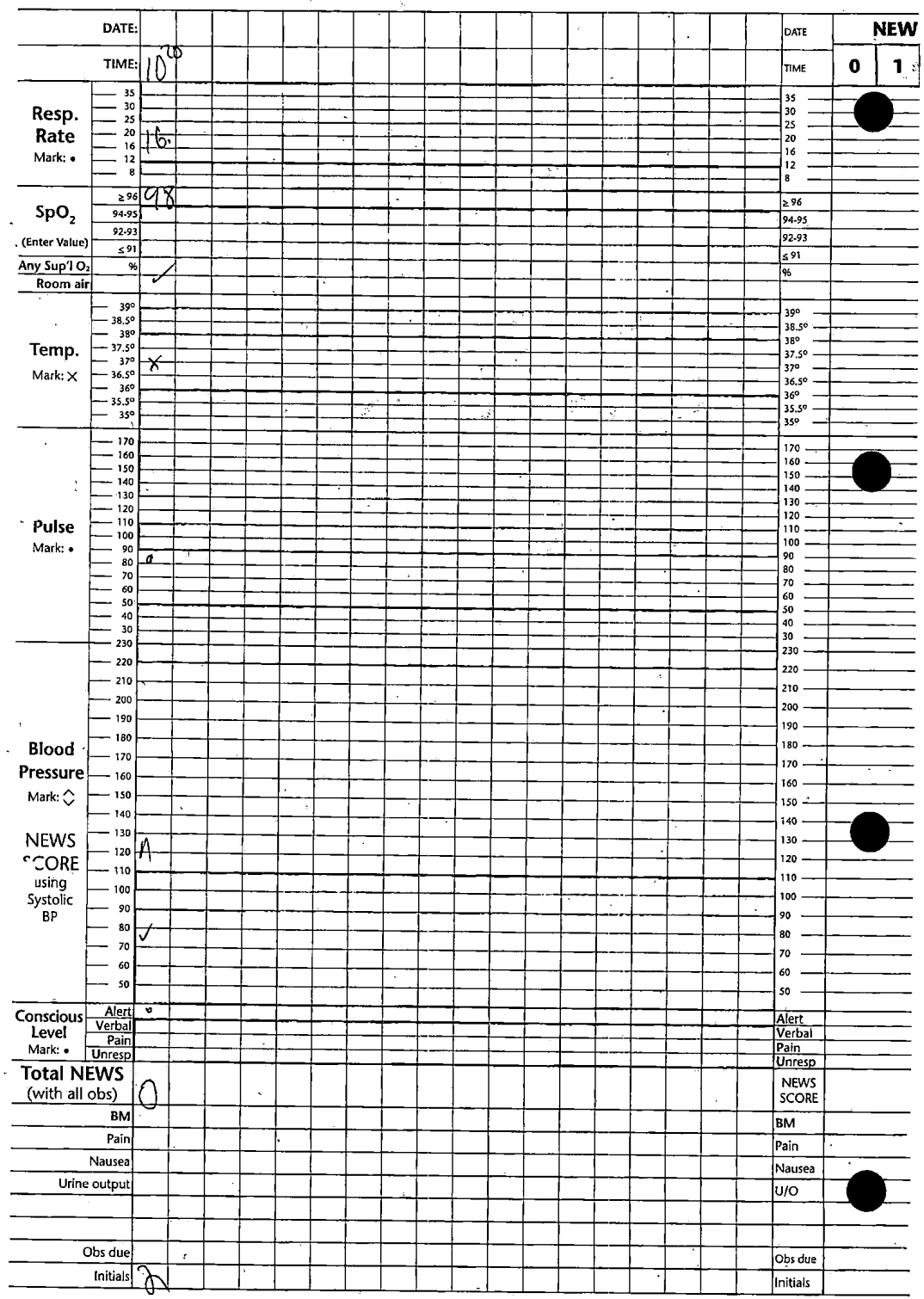
	Date	Ward
Admitted		
Transferred		
Transferred		

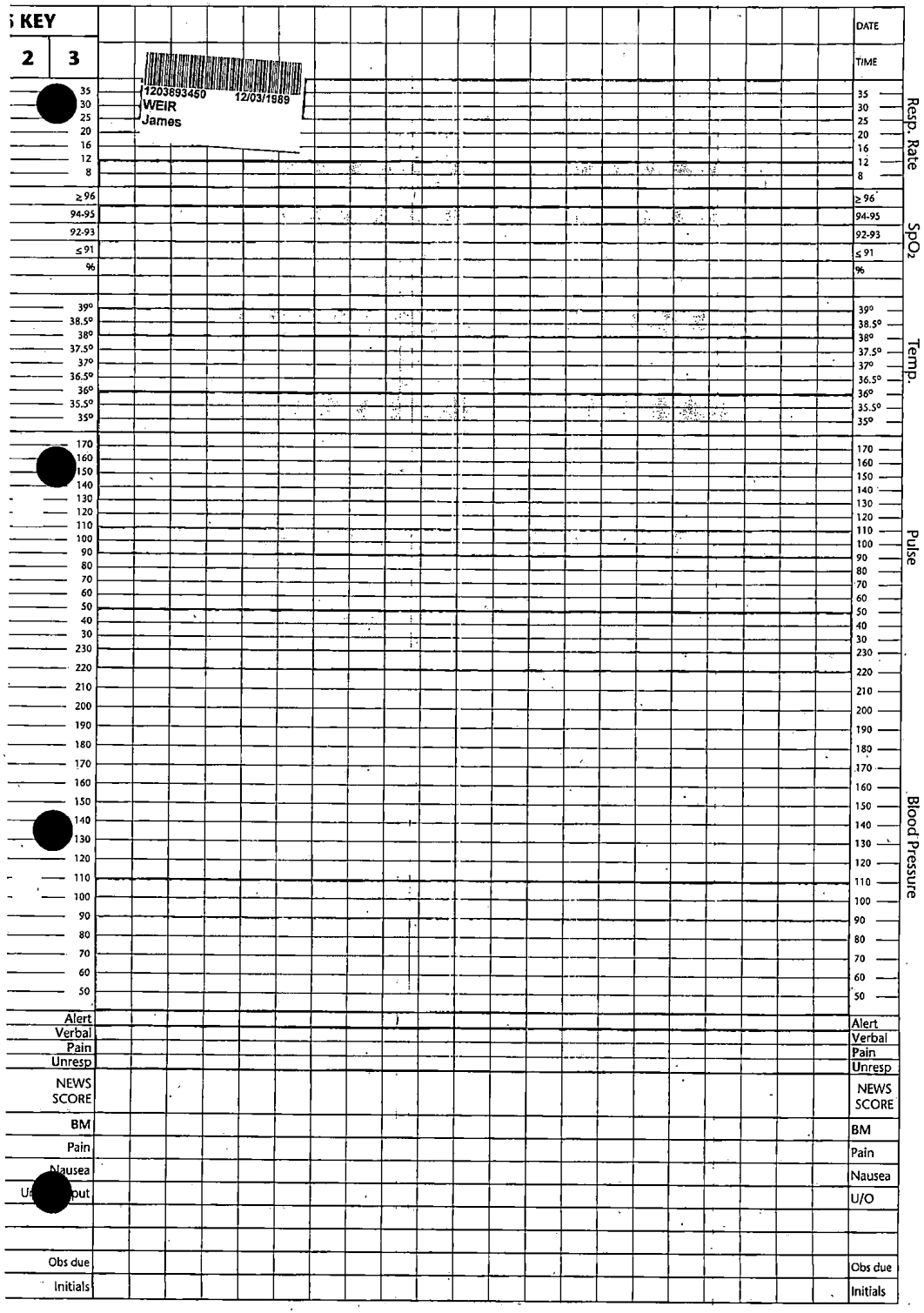
Physiological Parameter	NEWS – NHS Early Warning Score						
	3	2	1	0	1	2	3
Respiration Rate	≤8		9-11	12-20		21-24	≥25
Oxygen Saturations	≤91	92-93	94-95	≥96			
Any Supplemental Oxygen		Yes		No			
Temperature	≤35.0°		35.1-36.0°	36.1-38.0°	38.1-39°	≥39.1°	
Pulse	≤40		41-50	51-90	91-110	111-130	≥131
Systolic BP	≤90	91-100	101-110	111-219			≥220
Conscious Level				A			V, P or U

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

See NEWS Actions Reference Tool for local escalation policy

NEWS Score	Frequency of Monitoring	Clinical Response
0	Minimum 12 hourly	• Continue routine NEWS monitoring with every set of observations.
Aggregate 1- 4	Minimum 4 hourly	• Inform trained nurse. • Trained Nurse assessment: - Assess the patient - Review frequency of monitoring required - Assess need for escalation of clinical care and direct as appropriate.
Aggregate 5 or more or 3 in one parameter	Increased frequency to a minimum of 1 hourly	• Trained Nurse assessment. • Inform medical team caring for the patient. • Urgent assessment by a medical / surgical / nursing team with core competencies to assess acutely ill patients. • Consider level of monitoring required in relation to clinical care.
Aggregate 7 or more	Continuous monitoring of vital signs	• Trained Nurse to assess immediately. • Inform medical team caring for the patient – this should be at least senior medical staff level. • Emergency assessment by a clinical team with core competencies in the assessment of critically ill patients. This team will have critical care competencies and a practitioner/s with advanced airway skills and resuscitation skills. • Consider referral to high dependency or ITU.


DATE:
TIME: 1000
Resp. Rate
Mark: •
35
30
25
20
16
12
8
16
SpO2
(Enter Value)
≥ 96
94-95
92-93
≤ 91
98
Any Sup'l O2
%
Room air
✓
Temp.
Mark: ×
39°
38.5°
38°
37.5°
37°
36.5°
36°
35.5°
35°
×
Pulse
Mark: •
170
160
150
140
130
120
110
100
90
80
70
60
50
40
30
80
Blood Pressure
Mark: ◇
230
220
210
200
190
180
170
160
150
140
130
120
110
100
90
80
70
60
50
NEWS SCORE using Systolic BP
120
80
✓
Conscious Level
Mark: •
Alert
Verbal
Pain
Unresp
Total NEWS (with all obs)
0
BM
Pain
Nausea
Urine output
Obs due
Initials
DATE
TIME
NEW
0
1
NEWS SCORE
BM
Pain
Nausea
U/O
Obs due
Initials


KEY
2
3
1203893450
12/03/1989
WEIR
James
DATE
TIME
Resp. Rate
SpO2
Temp.
Pulse
Blood Pressure
Alert
Verbal
Pain
Unresp
NEWS SCORE
BM
Pain
Nausea
U/O
Obs due
Initials

Neurological Observations

| | | |

NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

(6)

Affix Label

CHI: 1203893450

Royal Alexandra Hospital

Total Att: **61**

12 Mth Att: **11**

Title: **MR**

WEIR **James**

DOB: **12/03/1989** Age: **25y** Sex: **Male**

Flat D
27 MacDowall Street
Johnstone
Renfrewshire
PA5 8QJ
07468282574

Next of kin: **GUTHERIE, Mary**
Relationship: **Mother**
01418480859

GP: **DA Foster**
01475 501246

Attendance Date: **01/03/2015** Arrival Time: **00:40**

Registration Time: **00:40** Date of Incident: **01/03/2015**

Major Incident Desc:

Reason for Attendance: **suicidial/ intoxicated**

Affix Label

Nursing Assessment

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

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

Presenting Complaint:

Observation Date: **01/03/2015 01:19** Nurse name: **Nurse Annette Johnston**

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

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

Visual Acuity	
Left	
Right	
Corrected?	

GCS	
Eyes	
Motor	
Verbal	
Total	

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

Nursing Notes: **contacted nhs 24 at 8pm last night saying he was feeling suicidal 2-3 bottles of buckfast since yesterday morning cpn could not properly assess pt due to alcohol intake pt c/o abdo pain and epigastric pain still feeling suicidal**

Child Assessment Questionnaire

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

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

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

DO NOT WRITE HERE PLEASE

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

Date	CLINICAL NOTES
	Seen by (Dr) Adams Time seen

(23) NAME

WELL KNOWN TO DEPARTMENT
LONG STANDING DEPRESSION + SUICIDAL THOUGHTS
LIVES ALONE
SMOKER / EATS MOST DAYS

SELF PRESENTATION WITH SUICIDAL IDEATION
ADMITS TO DRINKING TODAY
NO CURRENT SUICIDAL
PLANS TO RELATIONS AFTER ADMS "SORT LIFE OUT"
REMINDED NEEDS TO "GET LIFE ON TRACK"
GOOD EYE CONTACT + AFFECT
REASONS FOR CONTINUING LIVING
DENIES ANY OVERDOSE OR SELF HARM

CPN IS
HAS CAPACITY
NOT SUICIDAL

→ HOME WITH FAMILY
OWN FAMILY TO WATCH CPN

90.7.83

Date	CLINICAL NOTES
	 1203893450 12/03/1989 WEIR James

Discharge Codes (Please CIRCLE)					Discharge date	
1. Admission	2. Discharge	3. Refer to GP	4. Transfer to other (see below)			
5. Died	6. Refer to OP Clinic (see below)		7. Irregular Discharge	8. D.O.A.	Discharge time	

Ward number (if admitted):	Transfer to hospital:	Consultant If admitted):

Follow up	Arranged			Not arranged			To be arranged	
Clinic referred to	A&E	Hand injury	Fracture	Pop Check	Medical	Surgical	ENT	Others (specify):

Discharge Prescription Packs

Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Frequency	Signature	Given By

Designed by Medical Illustration Services ref 243836

Emergency Department Nursing Documentation

NHS Greater Glasgow and Clyde

Patient Addressograph Label

1203893450 12/03/1989
WEIR
James

Presenting Complaint: Suicidal

Date and Time: 01/03/18 02:30

Named Nurse(s): A Cassells

Patient preparation (Please tick when completed)	Initials: AC	Communication (Please tick when completed)	Initials:
Prepare patient for examination	☑	Communication Aids (spectacles / hearing aid)	☐
Provide blankets if required	☑	Relatives present? Police	☑
Clothing bagged, labelled and stored under trolley	☑	Relatives / NOK informed	☐
Name-band (if required)	☑	Interpreter required	☐
		Telephone interpretation required	☐

Observations and Investigations (Please tick when completed)		Initials:	
Vital Signs recorded on NEWS chart and NEWS score recorded. Record Pain, blood sugar and neuro obs on NEWS chart if appropriate.	☑	IV Cannula (if required) dated and timed	☐
Peak Flow 1. 2. 3.	☐	Blood samples taken	☐
12 Lead ECG	☐	Urinalysis and Specimen if indicated *Results:*	☐
Cardiac Monitoring	☐		
X-rays performed	☐	HCG specimen if indicated +ve ☐ -ve ☐ Strip Lot no:.	☐
Other: please add	☐	Weight:	☐

Screening Tools (Please circle or tick as appropriate)		Initials:	
SEPSIS risk? SIRS Criteria 2 or more and suspicion of infection	Y / N	**Preliminary Pressure Ulcer Risk Assessment** The patient can reposition themselves whilst in the department?	Y / N
AMT 4 (if >65 years) SCORE	/4	There is no reported skin damaged other than presenting trauma?	Y / N
At risk of falls? (clinical judgement) (consider alcohol, mobility, age, illness, cognitive impairment etc). *If at risk complete risk assessment*	Y / N	The person is fully continent? *If NO to any of the above initiate Waterlow risk assessment (within 4 hrs)*	Y / N
Mental Health Triage Assessment	Y / N	**Waterlow Score** *If >10 commence Active Care*	☐
Child Protection considered (in line with policy)	Y / N	**Active Care** (clinical judgement) (include all trolley patients at risk of pressure ulcers and all trolley patients in department for >4hrs) *Record on Active Care Chart*	☐
GMAWS	Y / N	Pressure damage identified on arrival in ED is documented in clinical notes	☐
Swallow test (If CVA/stroke)	Y / N	Grade 3 or 4 Pressure Ulcers are reported on DATIX	☐

Pause for Transfer (Please tick when completed)		Tick when completed	N/A	Notes
	Relatives informed	☐	☐	Information on discussion with relatives
	Cannula dated and timed	☐	☐	
	Name band	☐	☐	
	AMT4	☐	☐	
	NEWS chart	☐	Always	
Prescriptions signed	Infusions	☐	☐	
	Drugs	☐	☐	
	Fluids	☐	☐	
	GMAWS	☐	☐	
	Belongings (including patient's medications)	☐	Always	Please note here if any other tasks required prior to transfer
	Bed requested, accepted and ward informed	☐	Always	
	Notes: medical notes, GP letter, PRF	☐	Always	
Investigations	CXR reviewed	☐	☐	
	ECG reviewed	☐	☐	Print name
	Bloods sent	☐	☐	
	Bloods reviewed	☐	☐	
	Patient on O_2: cylinder checked	☐	☐	
	Patients requiring analgesia: sufficient	☐	☐	

Patient Addressograph Label

Pause for Discharge (Please tick when completed)	Tick when completed	N/A	Notes
Advice leaflets given	☐	☐	Information on discussion with relatives
Belongings (Including patient's medications)	☐	Always	
New medications explained	☐	☐	
Cannula removed	☐	☐	
Relatives aware of discharge	☐	☐	Please note here if any other tasks required prior to discharge
Social/ Support Services required and contacted	☐	☐	
SAS transport required and ref no	☐	☐	Print name
Other means of transport arranged by nurse	☐	☐	

Nursing Notes

Date and Time		Print Name and Signature
2.35	Into room prepared for examination.	ALessells

Patient Addressograph Label

120 389 3650

Nursing Notes

Date and Time		Print Name and Signature

Emergency Department - Active Care

I have evaluated and deemed that the frequency of care delivery over the next work shift, **based on the patient's most critical need** should be every:

(Please circle) **½ hour** **1hour** **2 hours**

Signed ..... Name .....

Patient Addressograph Label

			Time							
	1.	**PAIN: Assess and address** If in pain inform registered nurse **Y or N/A**								
S	2.	**SKIN INSPECTION** A. Pressure areas checked:								
		B. Redness (R) / Discolouration (D) / Pressure Ulcer (PU)								
K	3.	**KEEP MOVING:** A. Have you moved or walked **Y / N / I (independent)**								
		B. Trolley Right side (30° tilt) – **R** Left Side (30° tilt) – **L** Back– **B**								
		C. Chair Assist to walk, stand or tilt (**W /ST/ T**)								
I	4.	**ELIMINATION:** Do you need the toilet? **I** = Independent **A** = Assistance given **IC** = patient incontinent of urine/faeces								
N	5.	**FOOD, FLUIDS AND NUTRITION:** Is the patient nil by mouth? **Y / N** (consider mouth care)								
		Encourage the patient to drink? **(if appropriate) Y / N / N/A**								
		Food, snack or supplement taken? **(if appropriate) Y / N / N/A**								
	6.	**ENVIRONMENT:** Is the patient able to call for assistance? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the trolley in lowest position?								
	7.	**INFORMATION:** Ask: Is there anything else I can help you with? Inform patient of the time of return.								
	8.	**ESCALATION:** Escalate any issues to the Registered Nurse / Dr **Y / N/A**								
		Nurse Initials								

USE FOLLOWING CODE	Specialist Pressure Redistributing equipment	Variations			
V = Variant **I = Independent** **NT = No thanks**	☐ Repose Mattress ☐ Moving and handling aids ☐ Other:	Time	No.	Variation	Signed

Waterlow Pressure Area Risk Assessment

Build/Weight		Skin Type/Visual Risk Areas		Sex/Age		Special Risks - Tissue Malnutrition	
Average (BMI 20-24.9)	0	Healthy	0	Male	1	Multiple organ failure/ Terminal cachexia	8
Above Average (BMI 25-29.9)	1	Tissue Paper (thin/fragile)	1	Female	2		
Obese (BMI > 30)	2	Dry (appears flaky)	1	14-49	1	Single organ failure	5
Below Average (BMI < 20)	3	Oedematous (puffy)	1	50-64	2	Peripheral Vascular Disease	5
Continence		Clammy /pyrexia	1	65-74	3	Anaemia = Hb < 8	2
Complete/Catheterised	0	Discoloured (brusing/mottled)	2	75-80	4	Smoking	1
Incontinent urine	1			81+	5	**Neurological Deficit**	
Incontinent faeces	2	Broken (established ulcer)	3	**Nutritional Element**		Diabetes/MS/CVA Motor or sensory paraplegia (Max 6)	4-6
Doubly Incontinent (urine and faeces)	3	**Mobility**		Unplanned weight loss in past 3-6 months < 5% Score 0 5-10% Score 1 > 10% Score 2			
		Fully mobile	0				
Special Risks – Surgery/Trauma		Restless/Fidgety	1			**Special Risks - Medication**	
On table > 6 hours	8	Apathetic (sedated/depressed/ reluctant to move)	2			Cytotoxic, anti-inflammatory, long term/high dose steroids (Max 4)	4
Orthopaedic / below waist/Spinal (up to 48 hrs post-op)	5			BMI > 20 Score 0 BMI 18.5-20 Score 1 BMI < 18.5 Score 2			
On table > 2 hours (up to 48 hrs post op)	5	Bed bound (unconscious/unable to change position/traction)	4			**Risk Score** 10+ = 'At risk' 15+ = 'High Risk' 20+ = 'Very High Risk'	
		Chair Bound	5	Patient acutely ill or no nutritional intake > 5 days	2		

Patient's Initial Waterlow Score = **If Score ≥10 Complete the Adapted Waterlow Pressure Area Risk Assessment Chart**

Emergency Department Mental Health Assessment

This section to be completed by medical staff

outline of current presentation and precipitating factors

12038934 50

previous mental health problems, self harm, addictions, medication etc

other relevant information; relationships, finances, employment, housing, physical health, childcare etc

Appearance	Behaviour	Speech
Mood	Thought	Insight

Is the patient a carer for a child or dependent adult? Y/N

Is there a child protection concern? Y/N

Risk assessment

based on clinical assessment, indicate category of risk of further episode of self harm in the short term

consider protective as well as precipitating factors

High / Moderate / Low

negative responses in the 4 categories highlighted may allow patients to be categorised as low risk

Suicide Risk Factor	Yes	No	Unknown
male gender	y	n	u
age <18 or ≥65	y	n	u
depression	y	n	u
alcohol or drug use	y	n	u
separated, widowed, divorced	y	n	u
suicide plan/concealment	y	n	u
evidence of psychosis	y	n	u
ongoing suicial intent	y	n	u
lack of social support	y	n	u
chronic physical illness/pain	y	n	u
family history of suicide	y	n	u
family concern about risk	y	n	u
disengaged/poor compliance	y	n	u
unemployed or retired	y	n	u
access to lethal means of harm	y	n	u
previous violent methods	y	n	u
[illegible]	y	n	u
previous psychiatric admission	y	n	u
current psychiatric treatment	y	n	u
[illegible]	y	n	u

Summary and plan for further assessment

Can be referral to liaison psychiatry duty doctor, CPN service, voluntary sector, etc

Summary

Service referred to

time of referral

for patients awaiting assessment, indicate where they should wait, and who will supervise them; for patients to be transferred, indicate means of travel and anyone who will accompany them; for other outcomes, indicate the follow-up plan and name and relationship of the carers informed of this plan.

print name _____

signature _____

date _____ time _____

Glasgow Emergency Departments
Mental Health Triage and Risk Assessment

this side to be completed by triage nurse

name
DoB 12/03/1989
CHI 1203893450
WEIR
James

1. Triage observations

document physiological measurements

GCS	BM	HR	BP	RR	SaO²	Temp
15/15	4.9	95	116/68	14	97%	36.7

accompanied by

name, relationship, pertinent characteristics

1/c Police

briefly describe patients attending alone (they may leave before assessment)

2. Outline of presentation

tick all boxes as appropriate, provide brief details

overdose – will require medical assessment	
self-injury – will require wound management	
other mental health presentation	✓

3. Initial presentation, appearance and behaviour

respond yes or no to each question

Is the patient violent, aggressive or threatening?	Yes		(No)
Is the patient obviously distressed, markedly anxious or highly aroused?		(Yes)	(No)
Is the patient quiet and withdrawn?		(Yes)	No
Do you think the patient is behaving inappropriately to their situation?		Yes	(No)
Do you think the patient presents an immediate risk to you, to others, or to themselves?	(Yes)		No
Do you think the patient is likely to abscond prior to assessment?	(Yes)		No
Do you think the patient's presentation suggests either delusions or hallucinations?*	Yes		(No)
Do you think the patient's presentation suggests they feel their actions are being controlled?	Yes		(No)
Are you aware of a history of violence or self harm?		(Yes)	No
Are you aware of a history of mental health problems or psychiatric illness?		(Yes)	No

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

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

other patients can be categorized as → **Moderate Risk**

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

4. Triage Risk Assessment

indicate clinical category of risk based on responses and supporting information

High / Moderate / Low risk

of self-harm/violence/absconding in department

Triage Category	2	high risk – supervised *and* in the department moderate risk – supervised *or* in the department low risk – can be asked to wait if necessary

5. Immediate management

toxbase information for drug and alcohol overdose patients

Patient location, supervised by...	Police in CwA		
blood sample time?		toxbase information printed?	

print name A Johnston

signature A Johnston

date 1/3/15 time 0130

NEWS – National Early Warning Score

NHS
Greater Glasgow and Clyde

Name
Address

1203893450 12/03/1989
WEIR
James

CHI No.
DoB

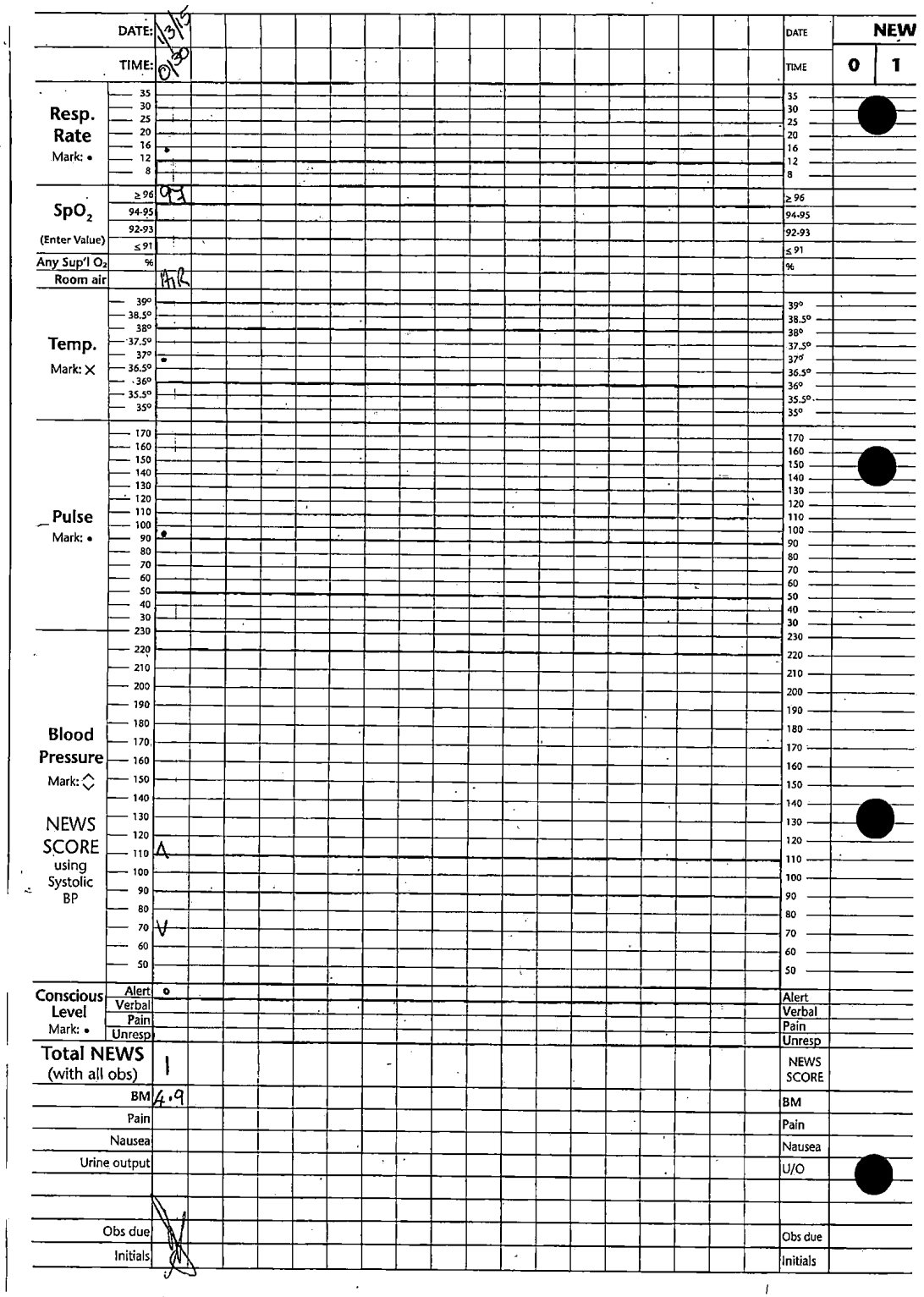
	Date	Ward
Admitted		
Transferred		
Transferred		

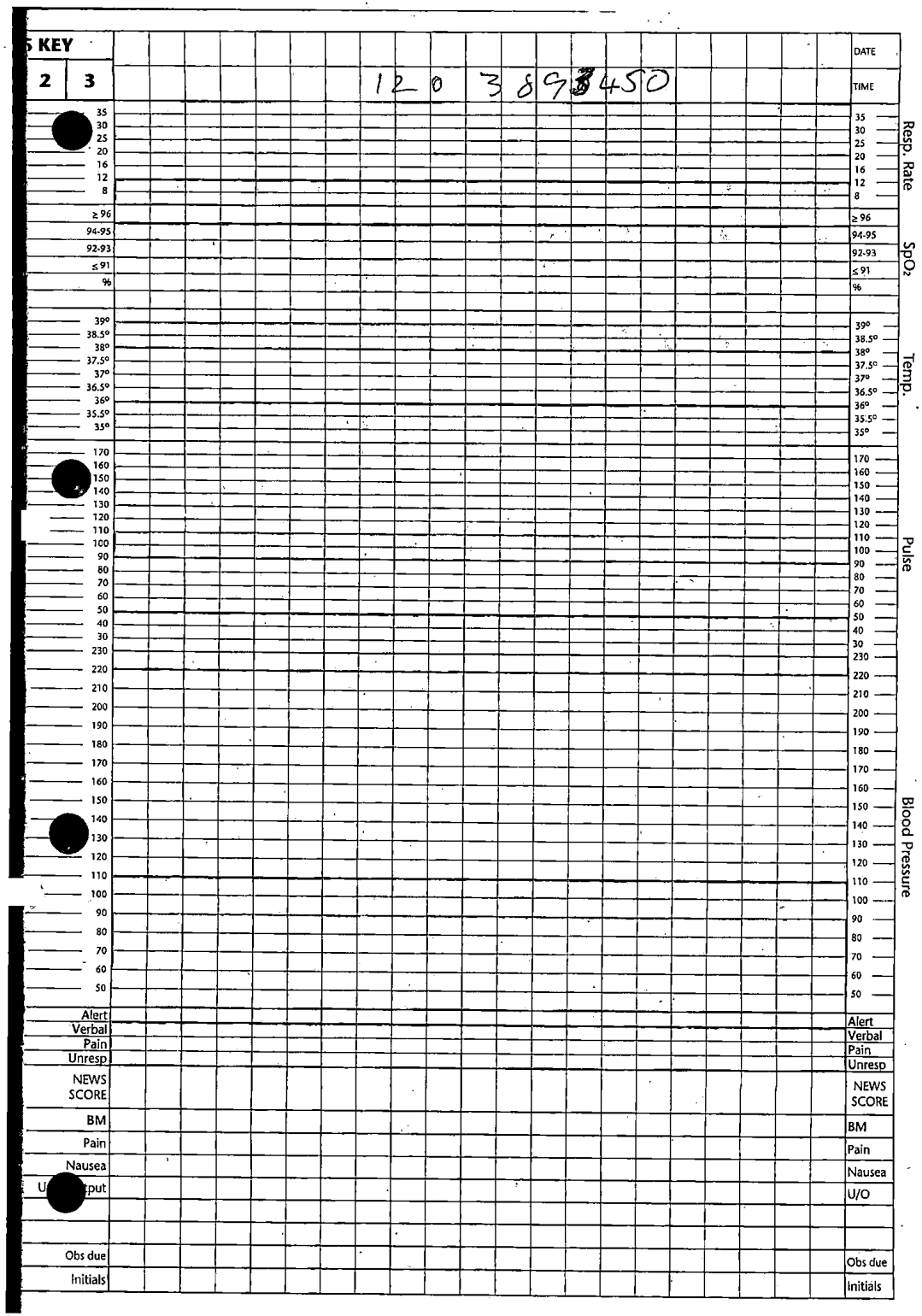
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Respiration Rate	≤8		9-11	12-20		21-24	≥25
Oxygen Saturations	≤91	92-93	94-95	≥96			
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Temperature	≤35.0°		35.1-36.0°	36.1-38.0°	38.1-39°	≥39.1°	
Pulse	≤40		41-50	51-90	91-110	111-130	≥131
Systolic BP	≤90	91-100	101-110	111-219			≥220
Conscious Level				A			V, P or U

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Aggregate 7 or more	Continuous monitoring of vital signs	• Trained Nurse to assess immediately. • Inform medical team caring for the patient – this should be at least senior medical staff level. • Emergency assessment by a clinical team with core competencies in the assessment of critically ill patients. This team will have critical care competencies and a practitioner/s with advanced airway skills and resuscitation skills. • Consider referral to high dependency or ITU.


DATE: 13/5
TIME: 0130
Resp. Rate
Mark: •
35 30 25 20 16 12 8
SpO2
(Enter Value)
≥ 96 94-95 92-93 ≤ 91
93
Any Sup'l O2
Room air
%
RA
Temp.
Mark: ×
39° 38.5° 38° 37.5° 37° 36.5° 36° 35.5° 35°
Pulse
Mark: •
170 160 150 140 130 120 110 100 90 80 70 60 50 40 30
Blood Pressure
Mark: ◇
230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50
NEWS SCORE using Systolic BP
4
Conscious Level
Mark: •
Alert
Verbal
Pain
Unresp
Total NEWS (with all obs)
1
BM
4.9
Pain
Nausea
Urine output
Obs due
Initials
DATE
TIME
NEW
0 1
NEWS SCORE
BM
Pain
Nausea
U/O
Obs due
Initials


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

Neurological Observations

| | | |

(PART 2 OF 2)

ELECTRONIC PATIENT RECORDS

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

Including:

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

0845650173 NHS GGC Hospitals, Emergency Department

01413147411 (7e)

NHS Greater Glasgow and Clyde

PLWA

CHI: 1203893450

Royal Alexandra Hospital

Total Att: **60**

12 Mth Att: **14**

Title: **MR**

WEIR **James**

DOB: **12/03/1989** Age: **25y** Sex: **Male**

69C DUNDONALD ROAD
Paisley
Renfrewshire
PA3 4NB
01418480859

Next of kin: **GUTHERIE, Mary**
Relationship: **Mother**
01418480859

GP: **CJ Johnstone**
0141 889 3732

Attendance Date: **16/12/2014** Arrival Time: **23:59**

Registration Time: **23:59** Date of Incident: **16/12/2014**

Major Incident Desc:

Reason for Attendance: **suicidal**

Nursing Assessment

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

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

Presenting Complaint:

Observation Date: **17/12/2014 00:11** Nurse name: **Nurse Gary Cooke**

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

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

GCS	
Eyes	
Motor	
Verbal	
Total	

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

Nursing Notes: **feeling suicidal, tearful and scared that he will hurt himself**

97607

Child Assessment Questionnaire

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

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

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

DO NOT WRITE HERE PLEASE

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

Date	CLINICAL NOTES

Discharge Codes (Please CIRCLE)						
1. Admission	2. Discharge	3. Refer to GP	4. Transfer to other (see below)		Discharge date	
5. Died	6. Refer to OP Clinic (see below)		7. Irregular Discharge	8. D.O.A.	Discharge time	

Ward number (if admitted):	Transfer to hospital:	Consultant If admitted):

Follow up	Arranged			Not arranged			To be arranged	
Clinic referred to	A&E	Hand injury	Fracture	Pop Check	Medical	Surgical	ENT	Others (specify):

Discharge Prescription Packs

Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Frequency	Signature	Given By

Designed by Medical Illustration Services ref 243836

Date	CLINICAL NOTES
	Seen by (Dr) SCHOFIELD Time seen 02.00
17/12/14	25y ♂ - suicidal Felt suicidal + got rope to hang himself - rang NHS Police were sent + brought him in Regrets ring. NHS - wants to die Has knives at home to use No alcohol Is depressed. Wants to go to sleep + not wake up Plan Psych r/w

1203893450 12/03/1989
WEIR
James

Glasgow Emergency Department
Mental Health Triage and Risk Assessment

this side to be completed by triage nurse

name _____
DoB _____
CHI _____

1. Triage observations

document physiological measurements

GCS	BM	HR	BP	RR	SaO^2	Temp

accompanied by:

with relationship, particular concerns

police

briefly describe patients attending alone (they may leave before assessment)

2. Outline of presentation

tick all those categories which apply and provide brief summary

overdose – will require medical assessment		Feels suicidal
self-injury – will require wound management		no family/friend support
other mental health presentation	✓	

3. Initial presentation: appearance and behaviour

respond yes or no to each question

Is the patient violent, aggressive or threatening?	Yes		(No)
Is the patient obviously distressed, markedly anxious or highly aroused?		(Yes)	No
Is the patient quiet and withdrawn?		(Yes)	No
Do you think the patient is behaving inappropriately to their situation?		Yes	(No)
Do you think the patient presents an immediate risk to you, to others, or to themselves?	(Yes)		No
Do you think the patient is likely to abscond prior to assessment?	(Yes)		No
Do you think the patient's presentation suggests either delusions or hallucinations?*	Yes		No
Do you think the patient's presentation suggests they feel their actions are being controlled?	Yes		(No)
Are you aware of a history of violence or self harm?		(Yes)	No
Are you aware of a history of mental health problems or psychiatric illness?		(Yes)	No

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

any responses in the first column
High Risk

other patients can be categorized as
Moderate Risk

unless all responses are in the third column
Low Risk

4. Triage Risk Assessment

indicate on the categorical risk scale the one selected from the risk factors

(High) / Moderate / Low risk

of self-harm/violence/absconding in department

Triage Category	2	high risk – supervised *and* in the department moderate risk – supervised *or* in the department low risk – can be asked to wait if necessary

5. Immediate management

print toxbase information and indicate time of blood sample

Patient location, supervised by...			
blood sample time?		toxbase information printed?	

print name Cooke
signature
date 17/12 time

Emergency Department Mental Health Assessment

this side to be completed by medical staff

outline of current presentation and precipitating factors

previous mental health problems, self harm, addictions, medication etc

other relevant information; relationships, finances, employment, housing, physical health, childcare etc

Appearance	Behaviour	Speech
Mood	Thought	Insight

Is the patient a carer for a child or dependent adult?	Y/N
Is there a child protection concern?	Y/N

Risk assessment

basis for clinical assessment, indicate risk factors for further episode of self harm in the short term, and consider both protective as well as precipitating factors

High / Moderate / Low

negative responses in the 4 categories highlighted may allow patients to be categorised as low risk

Suicide Risk Factors (yes/no/unknown)			
male gender	y	n	u
age <18 or >65	y	n	u
depression	y	n	u
alcohol or drug use	y	n	u
separated, widowed, divorced	y	n	u
suicide plan/concealment	y	n	u
evidence of psychosis	y	n	u
ongoing suicial intent	y	n	u
lack of social support	y	n	u
chronic physical illness/pain	y	n	u
family history of suicide	y	n	u
family concern about risk	y	n	u
disengaged/poor compliance	y	n	u
unemployed or retired	y	n	u
access to lethal means of harm	y	n	u
previous violent methods	y	n	u
child abuse (current/previous)	y	n	u
previous psychiatric treatment	y	n	u
current psychiatric treatment	y	n	u
impulsivity/aggression/lateness	y	n	u

Summary and plan for further assessment

referral to liaison psychiatry, crisis team, CMHT, GP, community services etc

Summary

Service referred to	time of referral

for patients awaiting assessment, indicate where they should wait, and who will supervise them; for patients to be transferred, indicate means of travel and anyone who will accompany them; for other outcomes, indicate the follow-up plan and name and relationship of the carers informed of this plan.

print name _____

signature _____

date _____ time _____

Out-of-Hours Psychiatric Nursing Service

NURSING ASSESSMENT

PATIENT DETAILS

Date: 17th Dec 2014
Name: James Weir
Address: 69C Dundonald Road, Paisley / 27D McDowall Street, Johnstone.
Post Code: PA3 4NB
DOB: 12/03/1989 (25)
Tel No:

PiMS No:
GP Name: Dr Johnstone.
GP Address:

Known to Service: YES ☐ NO ☑

If so, Consultant/Keyworker Name:

Time Triaged (24Hr): HR | MIN

Referrer: A+E Department R.A.H
Assessor: Liz Caw Charlie Goldie

Time Visited: HR 03 | MIN 30

Time Assessment/Contact Completed: HR 04 | MIN 40

Venue Patient See At:

Home ☐ GEMS Clinic ☐ Other ☐ (Please specify):

A&E ☑ Police ☐

Hospital ☐

HISTORY

1. Reason for Referral/History of Present Crisis:

Felt suicidal and reported that he had got a rope to hang himself. Patient called NHS 24 who in turn contacted the police; who attended his home address and transported him to the A+E Dept for review.

2. Relevant Psychiatric/Medical History/Present Medication:

Not presently involved with psychiatric services. History of contact with Addiction services. History of alcohol and poly drug use. At assessment reports being abstinent from both alcohol and drugs.

3. Mental State Assessment:

Will Include:	**Appearance/Behaviour, mood, Suicidal Ideation, Psychotic symptoms, Cognitive functioning, Thought process and insight**
May Include:	**Sleep, Appetite, Relevant substance abuse, Relevant personal history**

Patient asleep prior to C.P.Ns attending for assessment. Easily wakened. No evidence of acute intoxication during assessment process. Orientated in presentation. Speech of normal rate and tone. Needed encouragement to engage in assessment initially. Was valven negative about the benefits of speaking with the C.P.Ns, stating he wanted see a psychiatrist. At one point he walked out of the assessment and needed to be encouraged to come back in. On returning he was more able to communicate his difficulties. He report struggling to manage the distress associated to being abused sexually by another man, whom he states has recently moved into his neighbourhood. He describes using self-harm to manage his emotional distress, reporting a history of cutting and attempted strangulation. Positively he states he does not wish to continue to manage his distress in his manner and verbalised a wish to get help. At assessment described no concrete plans of a suicidal nature and highlighted a number of future plans, including moving into new accomodation in Johnstone later today and attending his GP to discuss referral to an appropriate support service. C.P.Ns offered to refer gentleman into local C.M.H.T for assessment of his mental health issues, however he decided that he would rather access this himself via his GP.

There is a well documented history of drug and alcohol misuse, however at assessment patient denied recent use and states he has been abstinent for some months.

Plans to return to his homeless accomodation this morning. Police will escort home.

Outcome of assessment shared with referring medical staff

C.P.N.

Summary

See main assessment.

Diagnosis:	ICD10 Code:	

Follow Up

1	Client to seek follow up via GP	☑
2	Client to contact Care Team	☐
3	CPN will contact Care Team	☐
4	Psychiatric medical opinion requested	☐
5	Admitted to hospital	☐
6	Urgent CMHT next day follow up	☐

Appropriate referral: Yes ☑ No ☐
(If No, explain):

Signature: Charlie Waller

NEWS – National Early Warning Score

NHS
Greater Glasgow and Clyde

Name
Address



CHI No.
DoB

	Date	Ward
Admitted		
Transferred		
Transferred		

Physiological Parameter	NEWS – NHS Early Warning Score						
	3	2	1	0	1	2	3
Respiration Rate	≤8		9-11	12-20		21-24	≥25
Oxygen Saturations	≤91	92-93	94-95	≥96			
Any Supplemental Oxygen		Yes		No			
Temperature	≤35.0°		35.1-36.0°	36.1-38.0°	38.1-39°	≥39.1°	
Pulse	≤40		41-50	51-90	91-110	111-130	≥131
Systolic BP	≤90	91-100	101-110	111-219			≥220
Conscious Level				A			V, P or U

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

See NEWS Actions Reference Tool for local escalation policy

NEWS Score	Frequency of Monitoring	Clinical Response
0	Minimum 12 hourly	• Continue routine NEWS monitoring with every set of observations.
Aggregate 1- 4	Minimum 4 hourly	• Inform trained nurse. • Trained Nurse assessment: - Assess the patient - Review frequency of monitoring required - Assess need for escalation of clinical care and direct as appropriate.
Aggregate 5 or more or 3 in one parameter	Increased frequency to a minimum of 1 hourly	• Trained Nurse assessment. • Inform medical team caring for the patient. • Urgent assessment by a medical / surgical / nursing team with core competencies to assess acutely ill patients. • Consider level of monitoring required in relation to clinical care.
Aggregate 7 or more	Continuous monitoring of vital signs	• Trained Nurse to assess immediately. • Inform medical team caring for the patient – this should be at least senior medical staff level. • Emergency assessment by a clinical team with core competencies in the assessment of critically ill patients. This team will have critical care competencies and a practitioner/s with advanced airway skills and resuscitation skills. • Consider referral to high dependency or ITU.

		DATE: 17/12																DATE	NEW 0	1
		TIME: 0000																TIME		
Resp. Rate Mark: •	35																	35		
	30																	30		
	25																	25		
	20																	20		
	16	16																16		
	12																	12		
	8																	8		
SpO_2 (Enter Value)	≥ 96	99																≥ 96		
	94-95																	94-95		
	92-93																	92-93		
	≤ 91																	≤ 91		
Any Sup'l O_2	%																	%		
Room air		✓																		
Temp. Mark: ×	39°																	39°		
	38.5°																	38.5°		
	38°																	38°		
	37.5°																	37.5°		
	37°																	37°		
	36.5°																	36.5°		
	36°																	36°		
	35.5°																	35.5°		
	35°	35.1																35°		
Pulse Mark: •	170																	170		
	160																	160		
	150																	150		
	140																	140		
	130																	130		
	120																	120		
	110																	110		
	100																	100		
	90																	90		
	80																	80		
	70	70																70		
	60																	60		
	50																	50		
	40																	40		
	30																	30		
Blood Pressure Mark: ^ v	230																	230		
	220																	220		
	210																	210		
	200																	200		
	190																	190		
	180																	180		
	170																	170		
	160																	160		
	150																	150		
	140																	140		
NEWS SCORE using Systolic BP	130	^																130		
	120																	120		
	110																	110		
	100																	100		
	90																	90		
	80																	80		
	70	✓																70		
	60																	60		
	50																	50		
Conscious Level Mark: •	Alert	o																Alert		
	Verbal																	Verbal		
	Pain																	Pain		
	Unresp																	Unresp		
Total NEWS (with all obs)		1																NEWS SCORE		
BM																		BM		
Pain																		Pain		
Nausea																		Nausea		
Urine output																		U/O		
Obs due																		Obs due		
Initials																		Initials		

Neurological Observations

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

Glasgow Coma Scale

Pupil size (mm)

- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8

Pain Score

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

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

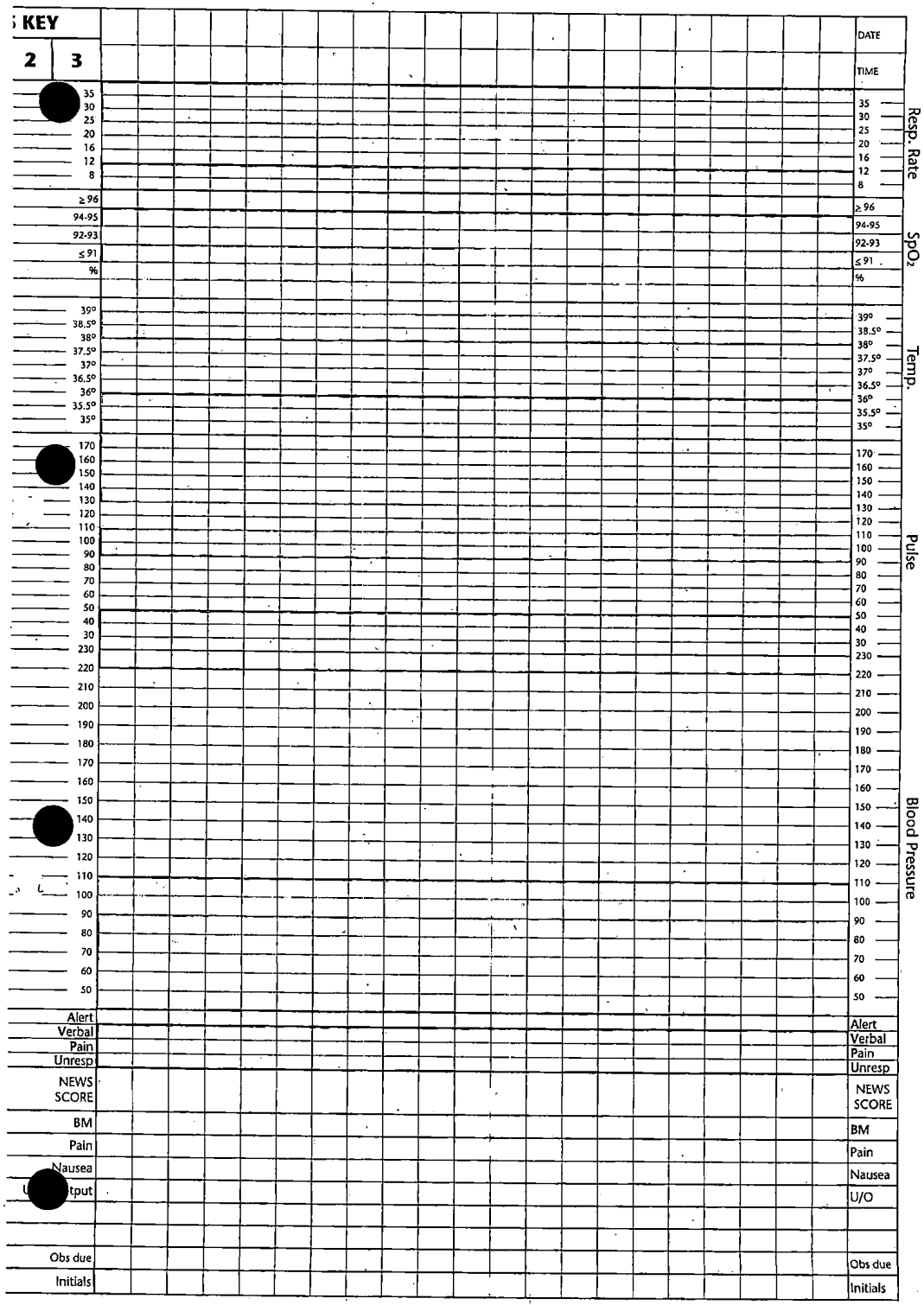
Nausea and Vomiting	
0	= None
1	= Mild (*Not distressing – no retching/vomiting*)
2	= Moderate (*Troublesome – occasional retching/vomiting*)
3	= Severe (*Distressing – frequent retching/vomiting*)

Management Plan and Patient Exclusions

Date and Time	Notes	Signed

Redesigned by Medical Illustration Services • 231261

97339


KEY
2
3
DATE
TIME
Resp. Rate
35
30
25
20
16
12
8
SpO2
≥ 96
94-95
92-93
≤ 91
%
Temp.
39°
38.5°
38°
37.5°
37°
36.5°
36°
35.5°
35°
Pulse
170
160
150
140
130
120
110
100
90
80
70
60
50
40
30
230
220
210
200
190
180
170
160
150
140
130
120
110
100
90
80
70
60
50
Blood Pressure
Alert
Verbal
Pain
Unresp
NEWS SCORE
BM
Pain
Nausea
U/O
Obs due
Initials

MINOR

GSA

NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

8C

Affix Label

Hospital (*circle*)	IRH	RAH	RHSC	GRI	WIG	VI	VIMIU	Stob	VOL	SGH

Title: | Sex: M ☐ F ☐

CHI: 1203893450

Royal Alexandra Hospital

Total Att: **59**

12 Mth Att: **14**

Title: **MR**

WEIR **James**

DOB: **12/03/1989** Age: **25y** Sex: **Male**

69C DUNDONALD ROAD

Paisley
Renfrewshire
PA3 4NB
01418480859

Next of kin: **GUTHERIE, Mary**
Relationship: **Mother**
01418480859

GP: **CJ Johnstone**
0141 889 3732

Attendance Date: **03/12/2014** Arrival Time: **19:22**

Registration Time: **19:22** Date of Incident: **03/12/2014**

Major Incident Desc:

Reason for Attendance: **left shoulder injury**

Nursing Assessment

Nursing Assessment

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

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

Presenting Complaint:

Observation Date: **03/12/2014 19:36** Nurse name: **Nurse Fiona Campbell**

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

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

Visual Acuity	
Left	
Right	
Corrected?	

GCS	
Eyes	
Motor	
Verbal	
Total	

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

Nursing Notes: **Pt came off a quad bike yesterday sustaining injury to (L) shoulder, arm and back. No head injury, has been to work today.**

Child Assessment Questionnaire

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

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

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

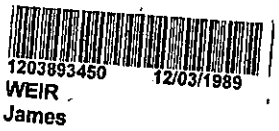
DO NOT WRITE HERE PLEASE

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

NEWS – National Early Warning Score

NHS
Greater Glasgow and Clyde

Name
Address



CHI No.
DoB

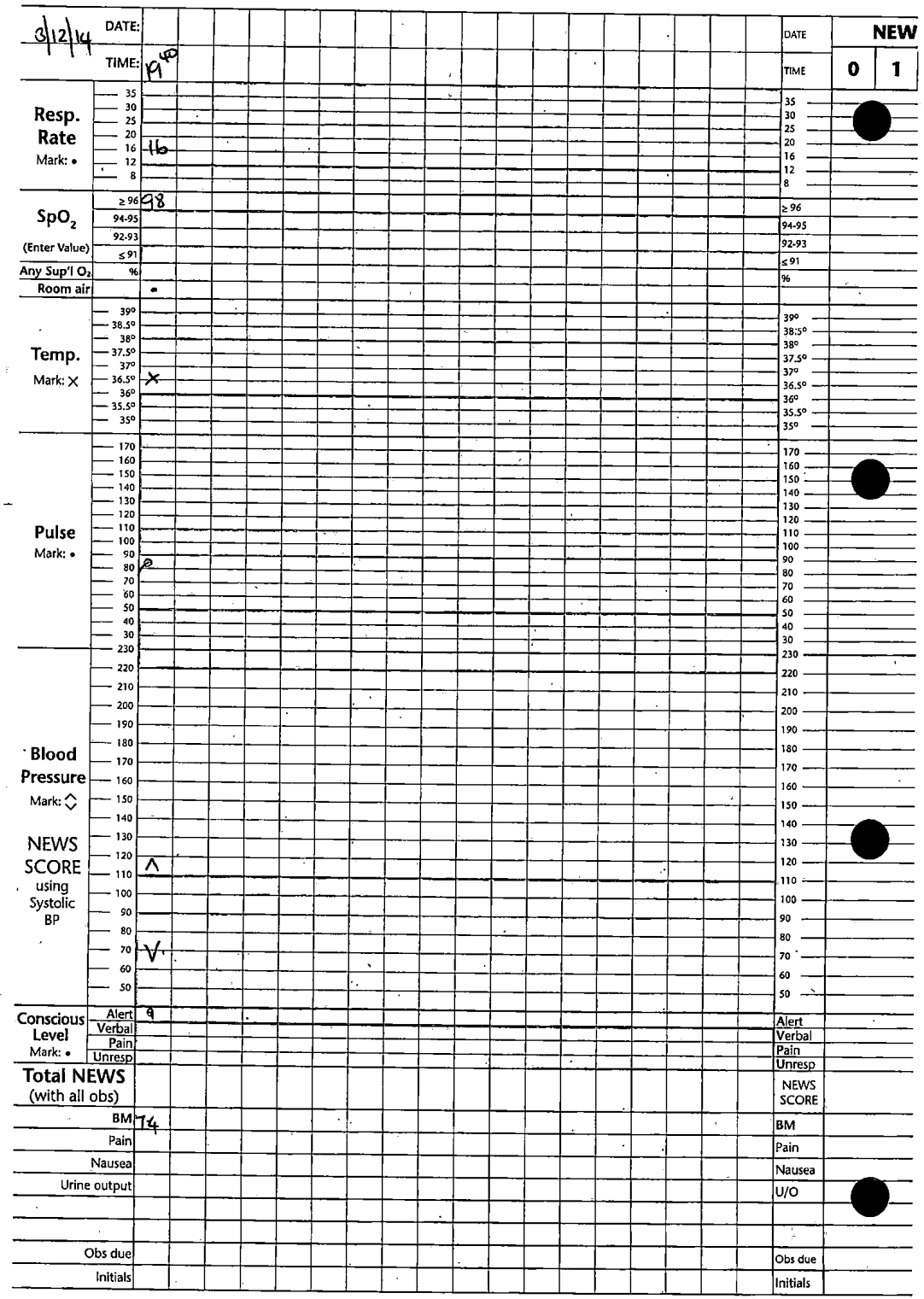
	Date	Ward
Admitted		
Transferred		
Transferred		

Physiological Parameter	NEWS – NHS Early Warning Score						
	3	2	1	0	1	2	3
Respiration Rate	≤8		9-11	12-20		21-24	≥25
Oxygen Saturations	≤91	92-93	94-95	≥96			
Any Supplemental Oxygen		Yes		No			
Temperature	≤35.0°		35.1-36.0°	36.1-38.0°	38.1-39°	≥39.1°	
Pulse	≤40		41-50	51-90	91-110	111-130	≥131
Systolic BP	≤90	91-100	101-110	111-219			≥220
Conscious Level				A			V, P or U

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Aggregate 1- 4	Minimum 4 hourly	• Inform trained nurse. • Trained Nurse assessment: - Assess the patient - Review frequency of monitoring required - Assess need for escalation of clinical care and direct as appropriate.
Aggregate 5 or more or 3 in one parameter	Increased frequency to a minimum of 1 hourly	• Trained Nurse assessment. • Inform medical team caring for the patient. • Urgent assessment by a medical / surgical / nursing team with core competencies to assess acutely ill patients. • Consider level of monitoring required in relation to clinical care.
Aggregate 7 or more	Continuous monitoring of vital signs	• Trained Nurse to assess immediately. • Inform medical team caring for the patient – this should be at least senior medical staff level. • Emergency assessment by a clinical team with core competencies in the assessment of critically ill patients. This team will have critical care competencies and a practitioner/s with advanced airway skills and resuscitation skills. • Consider referral to high dependency or ITU.


DATE: 3/12/14
TIME: 19:40
NEW
0 1
Resp. Rate
Mark: •
35 30 25 20 16 12 8
16
SpO2
(Enter Value)
≥ 96 94-95 92-93 ≤ 91 %
98
Any Sup'l O2
Room air
•
Temp.
Mark: X
39° 38.5° 38° 37.5° 37° 36.5° 36° 35.5° 35°
X
Pulse
Mark: •
170 160 150 140 130 120 110 100 90 80 70 60 50 40 30
80
Blood Pressure
Mark: ◇
230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50
NEWS SCORE using Systolic BP
Conscious Level
Mark: •
Alert Verbal Pain Unresp
Total NEWS (with all obs)
BM
Pain
Nausea
Urine output
Obs due
Initials
74

NHS 24 FAX REPORT

NHS 24 ID:	Call ID: 15427145	Site:	Ayrshire (& Arran)
CHI #:	1203853450	Caller Name:	
Surname:	WEIR	Date/Time Call Received:	03/12/2014 17:51
Forename:	JAMES		
DOB:	12/03/1989	Date Call Completed:	
Gender:	Male	Time Call Completed:	
Address:	69c Dundonald Road	Call Priority:	CS0
		Call Reason:	FELL OF QUAD BIKE 1/7 SEE AV.
	Paisley	Current Location:	69c Dundonald Road
	Renfrewshire/PA3 4NB		Paisley
PH NO:	07506475113 (Return)		Renfrewshire/PA3 4NB
		Special Directions:	Intercom/Buzzer Entry
		Current PH NO:	07506475113 (Return)
Care Provider:	JOHNSTONE, C	Care Provider Details:	NORTHCROFT MEDICAL CENTRE NORTHCROFT ST PAISLEY PA3 4AD Scotland
Temporary Resident:	No		

Referred To:	Glasgow and Clyde Hub	Recommended Action:	Pt advised to go to A&E - For Information Only

CLINICAL SUMMARY

FALL FROM QUAD BIKE FOR 1 DAY AND WAS GOING 50MPH DID 360 OVER HANDLE BARS AND DOWN STEEP HILL LANDING ON CHEST AREA ON A ROCK. FINDING IT PAINFUL TO BREATHE, ALSO SHOULDER APPEARS DEFORMED. HAS NUMBNESS IN LEFT ARM AND CHEST. OUTCOME: A&E ASAP RAH

PAST MEDICAL HISTORY

MEDICAL PROBLEMS

? STOMACH ULCER, IRREGULAR HEART BEAT, DEPRESSION

MEDICATIONS

NIL

ALLERGIES

PENICILLIN

Referred Clinical Notes:

T:

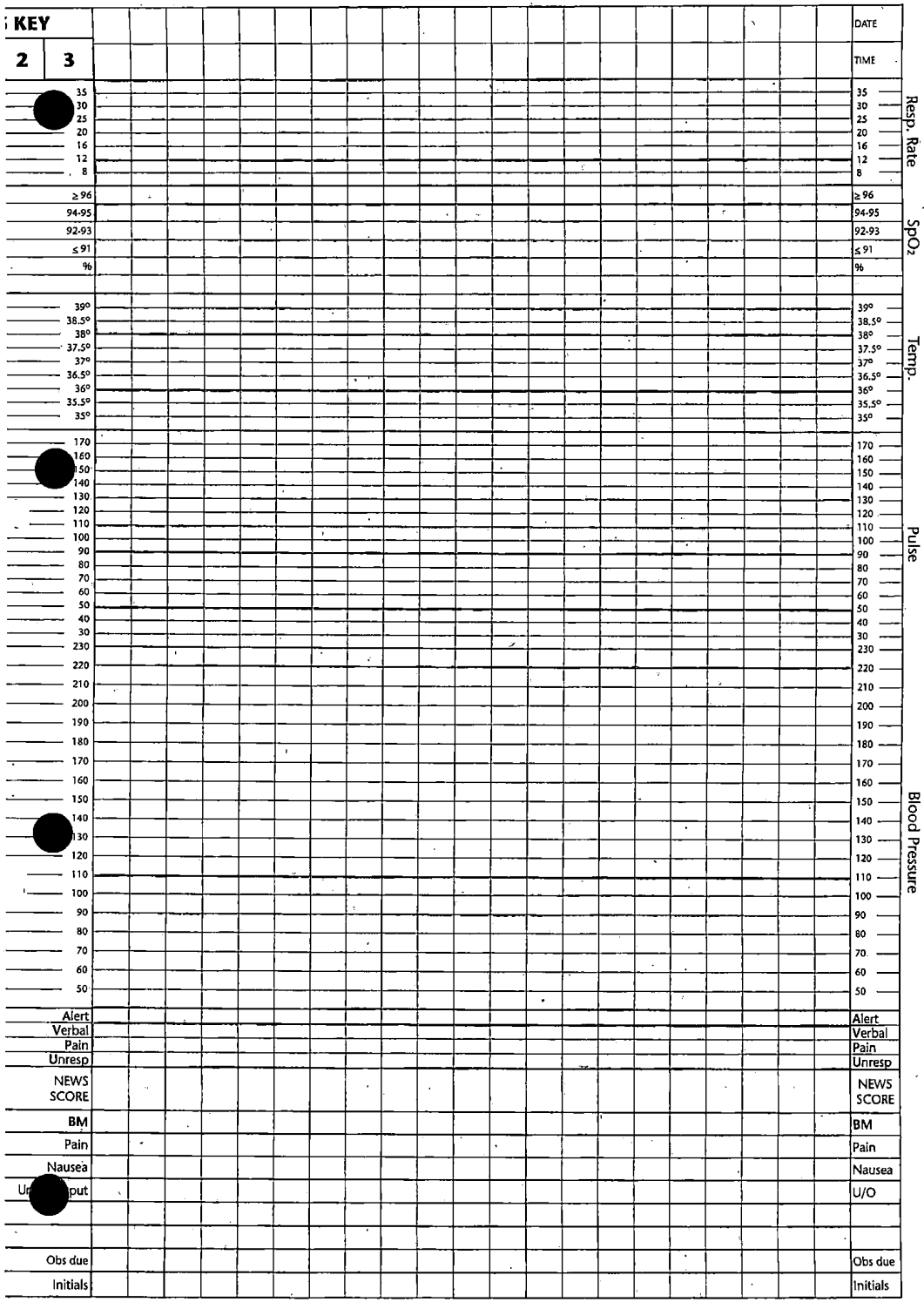
P:

R:

BP: /

Print Name:

Signature:


KEY
2
3
DATE
TIME
Resp. Rate
35
30
25
20
16
12
8
SpO2
≥ 96
94-95
92-93
≤ 91
%
Temp.
39°
38.5°
38°
37.5°
37°
36.5°
36°
35.5°
35°
Pulse
170
160
150
140
130
120
110
100
90
80
70
60
50
40
30
Blood Pressure
230
220
210
200
190
180
170
160
150
140
130
120
110
100
90
80
70
60
50
Alert
Verbal
Pain
Unresp
NEWS SCORE
BM
Pain
Nausea
U/O
Obs due
Initials

Neurological Observations

Date: 3/12/14					
Time: 1645					
COMA SCALE	E Eyes open	Spontaneously	4	4	Eyes closed by dwelling = C
		To speech	3		
		To pain	2		
		None	1		
	V Best Verbal response	Orientated	5	5	Endotracheal tube or tracheostomy = T
		Confused	4		
		Inappropriate words	3		
		Incomprehensible sounds	2		
		None	1		
	M Best motor response	Obeys	6	6	Usually record the best arm response
		Localises	5		
		Flexion - withdrawal	4		
		Flexion - abnormal	3		
		Extension to pain	2		
		None	1		
		TOTAL SCORE			
PUPILS	R	Size		4	+ reacts – no reaction C. eyes closed
		Reaction		+	
	L	Size		4	
		Reaction		+	
LIMB MOVEMENT	ARMS	Normal power		5	Record right (R) and left (L) separately if there is a difference between the two sides
		Mild weakness			
		Severe weakness			
		Spastic flexion			
		Extension			
		No response			
	LEGS	Normal power		5	
		Mild weakness			
		Severe weakness			
		Spastic flexion			
		Extension			
		No response			

Glasgow Coma Scale

Pupil size (mm)

1
2
3
4
5
6
7
8

Pain Score

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

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

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

Management Plan and Patient Exclusions

Date and Time	Notes	Signed

Dedsigned by Medical Illustration Services • 231261

Date	CLINICAL NOTES
	Seen by (Dr) Hinsith Time seen 21.40
31/12/14	Fall of quad bike yesterday. Was riding quad bike at 50mph; hit rock, when went over handlebars landing on back. Since full pain on movement of shoulder and pleuritic chest pain. No SOB No head injury, no other injuries. On exam: tender over left humeural head, ↓ROM also tender on scapular - says sharp pain neurovascular intact. No power, tone ~~+ reflex~~, sensation normal in upper limbs chest clear good entry NN by consultant ~~Dr~~ send for CXR + XRAY left shoulder ? # / displacement X-RAYS - nil fractures seen, nil humeral displacement plan - home with simple analgesia. Hinsith #5667

Date	CLINICAL NOTES

Discharge Codes (Please CIRCLE)						Discharge date	
1. Admission	2. Discharge	3. Refer to GP	4. Transfer to other (see below)				
5. Died	6. Refer to OP Clinic (see below)		7. Irregular Discharge	8. D.O.A.		Discharge time	

Ward number (if admitted):	Transfer to hospital:	Consultant if admitted):

Follow up	Arranged			Not arranged			To be arranged	
Clinic referred to	A&E	Hand injury	Fracture	Pop Check	Medical	Surgical	ENT	Others (specify):

Discharge Prescription Packs

Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Frequency	Signature	Given By

Designed by Medical Illustration Services ref 243836

NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

Affix Label

Hospital (circle) | IDU | DATE

Royal Alexandra Hospital

CHI: 1203893450

Total Att: 58

12 Mth Att: 19

Title: **MR**

WEIR

James

DOB: **12/03/1989**

Age: **25y**

Sex: **Male**

3B MITCHELL AVENUE
Renfrew
Renfrewshire
PA4 8DT
01418480859

Next of kin: **GUTHERIE, Mary**
Relationship: **Mother**
01418480859

GP: **A Sunderland**
0141 207 7700

Attendance Date: **18/08/2014**

Arrival Time: **22:01**

Registration Time: **22:01**

Date of Incident: **18/08/2014**

Major Incident Desc:

Reason for Attendance: **abdo pain**

Nursing Assessment

Alerts: **Not Recorded**

Allergies: **Yes**

Pain Score:

Triage Category: **3**

Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: **18/08/2014 22:28**

Nurse name: **Nurse Donna Law**

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

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

Visual Acuity	
Left	
Right	
Corrected?	

GCS	
Eyes	
Motor	
Verbal	
Total	

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

Nursing Notes: **d/c yest after alcohol withdrawal, feels symptoms have not resolved. c/o abdo pain and vomiting**

97607

Child Assessment Questionnaire

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

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

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

DO NOT WRITE HERE PLEASE

ONCE ONLY PRESCRIPTIONS (including Tetanus Prophylaxis)						
Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Time of Administration	Signature	Given By
19/8/14	ONDANSETRON	4mg	O			
19/8/14	PEPTAC	10ml	O			
19/8/14	LANSOPRAZOLE	30mg	O			
19/8/14	PROCHLORPERAZINE	3mg	BUCCAL			

Date	CLINICAL NOTES
	Seen by (Dr) RACHEL CLEGHORNE (FY2) Time seen 01.50.
19/8/14	PC:- Abdominal Pain.

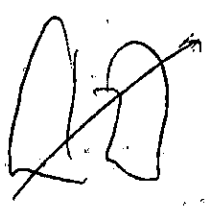
HPC:- 3/7 hx of intermittent abdominal pain, vomiting + shivers.
Had last drink of alcohol 4/7 ago. Admissions x2 last week.
13/8/14 - admitted for ?OD. Patient reports he tried to hang himself.
Admitted 15/8/14 with abdominal pain & symptoms 2° to Alcohol withdrawal.
DIC following many. Patient feels he should have been kept in
as ward treatment for alcohol withdrawal.
↓appetite. Bowels mainly as normal. No loose stools. Last vomited prior
to arriving in department → yellow. ° Urinary symptoms.

PMH:- Depression
- Anxiety
- Prev. Abdo pain post-alcohol consumption - ?alcohol gastritis.

DHx:- Nil
Allergies:- Penicillin

SHx- Lives with. brother.
- Does not work.
- Smokes 10-20/d.
- drinks ? >10 units/day.
- Alcohol x3

Ugly comfortably, sleeping initially. °sweaty, °jaundice °pale, °tremor.
0/E NR 16, Sats 96%, HR 70, BP 135/85, GCS 15. Appears
HS I + II + 0. CRT < 2 sec.
Resp



Air entry +ve.
No added sounds.



Mild pain
RUQ
°guarding
BS present
°organomegaly.

PR - Not assessed.

Date	CLINICAL NOTES
19/8/14	Imp :- Anxiety +/- Alcohol related anxiety P - D/C home - advise to attend GP for Rx re: Alcohol withdrawal (Thiamine etc OP appt booked) - Supply of Lansoprazole for home. - Lansoprazole + Ondansetron + peptac in dept.

Discharge Codes (Please CIRCLE)					Discharge date	19/8/14
1. Admission	2. Discharge	3. Refer to GP	4. Transfer to other (see below)		Discharge time	
5. Died	6. Refer to OP Clinic (see below)	7. Irregular Discharge	8. D.O.A.			

Ward number (if admitted):	Transfer to hospital:	Consultant If admitted):

Follow up	Arranged			Not arranged			To be arranged	
Clinic referred to	A&E	Hand injury	Fracture	Pop Check	Medical	Surgical	ENT	Others (specify):

Discharge Prescription Packs

Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Frequency	Signature	Given By
19/8/14	LANSOPRAZOLE	30mg		OD		

al GCS motor response | Obeys commands

VITAL SIGNS

Time hr : min	Pulse bpm	Pulse rhythm	Resp. rpm	BP mm Hg	Cap refill (secs)	Peak flow %	Blood sugar mmol / l	Pain score	Temp °C	SpO2 %	GCS Total	NEWS	RTS	ECG	Sepsis
:02	84	Reg	14	144 / 84	<2 secs	-	5.6	6/10	36.6	100	15	0	7.6	-	0
:12	80	Reg	14	141 / 81	<2 secs	-	-	-	-	100	15	-	7.6	-	0
:32	71	Reg	14	135 / 80	<2 secs	-	-	-	-	98	15	-	7.6	NSR	0
	-	-	-	- / -	-	-	-	-	-	-	-	-	-	-	0

SEPSIS

eps s: Pneumonia
eps s: UTI
aps s: Other infection
eps s: Abdo pain
eps s: Diarrhoea
eps s: Abdo distension
eps s: Meningitis
eps s: Cellulitis
s: Septic arthritis
s: Wound infection
eps s: Infected indwelling evice

EYES AND PUPIL SIZE AND REACTION

	Left	Right
up size	Normal	Normal
up reaction	Normal	Normal

AMPLE

Allergies	Antibiotics
Other allergies	
Medication	VENEFLAXAIN
Past history	ALCOHOL PROBS, DEPRESSION.
Last eaten	>5 hrs
Events prior	PT WITH R/SIDED ABDO PAIN ALL DAY TODAY, PT HAS ALSO BEEN VOMITING ALL DAY. PT ALSO C/O CHEST TIGHTNESS.

EMERGENCY SERVICES ON SCENE

Rapid Response Unit (RRU) | Paramedic

ETHNICITY

Ethnicity White	British
te Other	
stated	

FINAL OBSERVATION AND COMMENTS

WITH DRAWL FROM ALCOHOL SINCE FRIDAY, WAS AT RAH ON SATURDAY ADVISED TO STAY FOR TREATMENT BUT WAS DISCHARGED ON SUNDAY WITH NO MEDS. PT WAS UNABLE TO GET A GP APPOINTMENT TODAY

Report ID	2e1f9547-9b8a-43a5-ad48-4af7580c912a

E-Pacer PATIENT REPORT

Time 21:56 | Date 18/08/2014

PATIENT AND INCIDENT DETAILS

Incident number	CR000522402.001
Name	JAMES WEIR
Age	25Y
Date of birth	12/03/1989
Gender	Male
CHI number	1203893450
Incident location	3B MITCHELL AVENUE
Incident post code	RENFREW
Incident type	PA4 8DT
Call received	EMG
Call passed	18/08/2014, 20:50
Crew mobile	18/08/2014, 21:35
Crew at scene	18/08/2014, 21:36
Crew left scene	18/08/2014, 21:42
Receiving hospital and department	18/08/2014, 21:46. RAHP Royal Alexandra - Paisley

PRIMARY SURVEY

RESPONSE

AVPU | Alert

AIRWAY

Airway assessment | Clear

BREATHING

Breathing rate	Normal
Respiratory rate	

CIRCULATION

Pulse rate	Normal
Most peripheral pulse found	Radial
Cap refill rate	
Skin colour	Pale
Skin texture	Dry

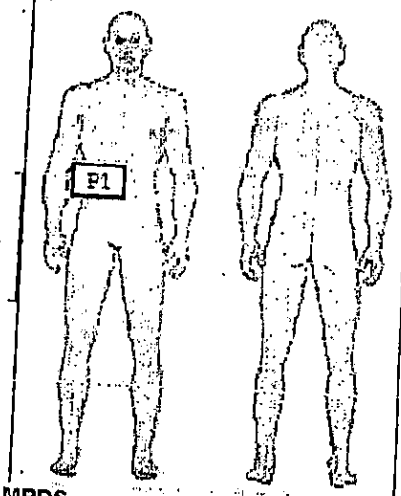
C-SPINE INJURY

Suspicion of CSI | No evidence of C-spine injury

PATIENT CONSENT

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

INJURIES



PAIN

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

AMPDS

patch code	33C04
al code	01A01

Poss acute heart prob or MI
Abdominal Pain

GCS

l GCS eye opening	Spontaneous
l GCS verbal response	Orientated

Emergency Department Nursing Documentation

NHS Greater Glasgow and Clyde

Patient Addressograph Label
1203893450 12/03/1989
WEIR
James

Presenting Complaint: Abdo Pain

Date and Time: 19/8/14 00:45 Into room.

Named Nurse(s): S. HERBURN

Patient preparation (Please tick when completed)	Initials:	Communication (Please tick when completed)	Initials:
Prepare patient for examination	☑	Communication Aids (spectacles / hearing aid)	☐
Provide blankets if required	☑	Relatives present?	☐
Clothing bagged, labelled and stored under trolley	☑	Relatives / NOK informed	☐
Name-band (if required)	☑	Interpreter required	☐
		Telephone interpretation required	☐

Observations and Investigations (Please tick when completed)		Initials:	
Vital Signs recorded on NEWS chart and NEWS score recorded. Record Pain, blood sugar and neuro obs on NEWS chart if appropriate.	☑	IV Cannula (if required) dated and timed	☐
Peak Flow 1. 2. 3.	☐	Blood samples taken	☐
12 Lead ECG	☐	Urinalysis and Specimen if indicated *Results:*	☐
Cardiac Monitoring	☐		
X-rays performed	☐	HCG specimen if indicated +ve ☐ -ve ☐ Strip Lot no:	☐
Other: please add	☐	Weight:	☐

Screening Tools (Please circle or tick as appropriate)		Initials:	
SEPSIS risk? SIRS Criteria 2 or more and suspicion of infection	Y / N	**Preliminary Pressure Ulcer Risk Assessment** The patient can reposition themselves whilst in the department?	Y / N
AMT 4 (if >65 years) SCORE	N/A	There is no reported skin damaged other than presenting trauma?	Y / N
At risk of falls? (clinical judgement) (consider alcohol, mobility, age, illness, cognitive impairment etc). *If at risk complete risk assessment*	Y / N	The person is fully continent? *If NO to any of the above initiate Waterlow risk assessment (within 4 hrs)*	Y / N
Mental Health Triage Assessment	Y / N	**Waterlow Score** *If >10 commence Active Care*	☒
Child Protection considered (in line with policy)	Y / N	**Active Care** (clinical judgement) (include all trolley patients at risk of pressure ulcers and all trolley patients in department for >4hrs) *Record on Active Care Chart*	☒
GMAWS	Y / N	Pressure damage identified on arrival in ED is documented in clinical notes	☒
Swallow test (If CVA/stroke)	Y N	Grade 3 or 4 Pressure Ulcers are reported on DATIX	☒

Pause for Transfer (Please tick when completed)		Tick when completed	N/A	Notes
	Relatives informed	☐	☐	Information on discussion with relatives
	Cannula dated and timed	☐	☐	
	Name band	☐	☐	
	AMT4	☐	☐	
	NEWS chart	☐	Always	
Prescriptions signed	Infusions	☐	☐	
	Drugs	☐	☐	
	Fluids	☐	☐	
	GMAWS	☐	☐	
	Belongings (including patient's medications)	☐	Always	Please note here if any other tasks required prior to transfer
	Bed requested, accepted and ward informed	☐	Always	
	Notes: medical notes, GP letter, PRF	☐	Always	
Investigations	CXR reviewed	☐	☐	
	ECG reviewed	☐	☐	Print name
	Bloods sent	☐	☐	
	Bloods reviewed	☐	☐	
	Patient on O_2: cylinder checked	☐	☐	
	Patients requiring analgesia: sufficient	☐	☐	

Patient Addressograph Label

Pause for Discharge (Please tick when completed)	Tick when completed	N/A	Notes
Advice leaflets given	☐	☐	Information on discussion with relatives
Belongings (including patient's medications)	☐	Always	
New medications explained	☐	☐	
Cannula removed	☐	☐	
Relatives aware of discharge	☐	☐	Please note here if any other tasks required prior to discharge
Social/ Support Services required and contacted	☐	☐	
SAS transport required and ref no	☐	☐	Print name
Other means of transport arranged by nurse	☐	☐	

Nursing Notes

Date and Time		Print Name and Signature

Emergency Department - Active Care

I have evaluated and deemed that the frequency of care delivery over the next work shift, based on the patient's most critical need should be every:

(Please circle) ½ hour 1hour 2 hours

Signed ..... Name .....

Patient Addressograph Label

			Time							
	1.	**PAIN: Assess and address** If in pain inform registered nurse **Y or N/A**								
S	2.	**SKIN INSPECTION** A. Pressure areas checked:								
		B. Redness (R) / Discolouration (D) / Pressure Ulcer (PU)								
K	3.	**KEEP MOVING:** A. Have you moved or walked **Y / N / I (independent)**								
		B. Trolley Right side (30° tilt) – **R** Left Side (30° tilt) – **L** Back– **B**								
		C. Chair Assist to walk, stand or tilt (W /ST/ T)								
I	4.	**ELIMINATION:** Do you need the toilet? I = Independent A = Assistance given IC = patient incontinent of urine/faeces								
N	5.	**FOOD, FLUIDS AND NUTRITION:** Is the patient nil by mouth? **Y / N** (consider mouth care)								
		Encourage the patient to drink? **(if appropriate) Y / N / N/A**								
		Food, snack or supplement taken? **(if appropriate) Y / N / N/A**								
	6.	**ENVIRONMENT:** Is the patient able to call for assistance? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the trolley in lowest position?								
	7.	**INFORMATION: Ask:** Is there anything else I can help you with? Inform patient of the time of return.								
	8.	**ESCALATION:** Escalate any issues to the Registered Nurse / Dr **Y / N/A**								
		Nurse Initials								

USE FOLLOWING CODE	Specialist Pressure Redistributing equipment	Variations			
V = Variant I = Independent NT = No thanks	☐ Repose Mattress ☐ Moving and handling aids ☐ Other:	Time	No.	Variation	Signed

Waterlow Pressure Area Risk Assessment

Build/Weight		Skin Type/Visual Risk Areas		Sex/Age		Special Risks - Tissue Malnutrition	
Average (BMI 20-24.9)	0	Healthy	0	Male	1	Multiple organ failure/ Terminal cachexia	8
Above Average (BMI 25-29.9)	1	Tissue Paper (thin/fragile)	1	Female	2		
Obese (BMI > 30)	2	Dry (appears flaky)	1	14-49	1	Single organ failure	5
Below Average (BMI < 20)	3	Oedematous (puffy)	1	50-64	2	Peripheral Vascular Disease	5
Continence		Clammy /pyrexia	1	65-74	3	Anaemia = Hb < 8	2
Complete/Catheterised	0	Discoloured (brusing/mottled)	2	75-80	4	Smoking	1
Incontinent urine	1			81+	5	**Neurological Deficit**	
Incontinent faeces	2	Broken (established ulcer)	3	**Nutritional Element**		Diabetes/MS/CVA Motor or sensory paraplegia (Max 6)	4-6
Doubly Incontinent (urine and faeces)	3	**Mobility**		Unplanned weight loss in past 3-6 months < 5% Score 0 5-10% Score 1 > 10% Score 2			
		Fully mobile	0				
Special Risks – Surgery/Trauma		Restless/Fidgety	1			**Special Risks - Medication**	
On table > 6 hours	8	Apathetic (sedated/depressed/ reluctant to move)	2			Cytotoxic, anti-inflammatory, long term/high dose steroids (Max 4)	4
Orthopaedic / below waist/Spinal (up to 48 hrs post-op)	5			BMI > 20 Score 0 BMI 18.5-20 Score 1 BMI < 18.5 Score 2			
On table > 2 hours (up to 48 hrs post op)	5	Bed bound (unconscious/unable to change position/traction)	4			**Risk Score** 10+ = 'At risk' 15+ = 'High Risk' 20+ = 'Very High Risk'	
		Chair Bound	5	Patient acutely ill or no nutritional intake > 5 days	2		

Patient's Initial Waterlow Score = If Score ≥10 Complete the Adapted Waterlow Pressure Area Risk Assessment Chart

Patient Addressograph Label

Nursing Notes

Date and Time		Print Name and Signature

NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

Name
Address

1203893450 12/03/1989
WEIR
James

CHI No.
DoB

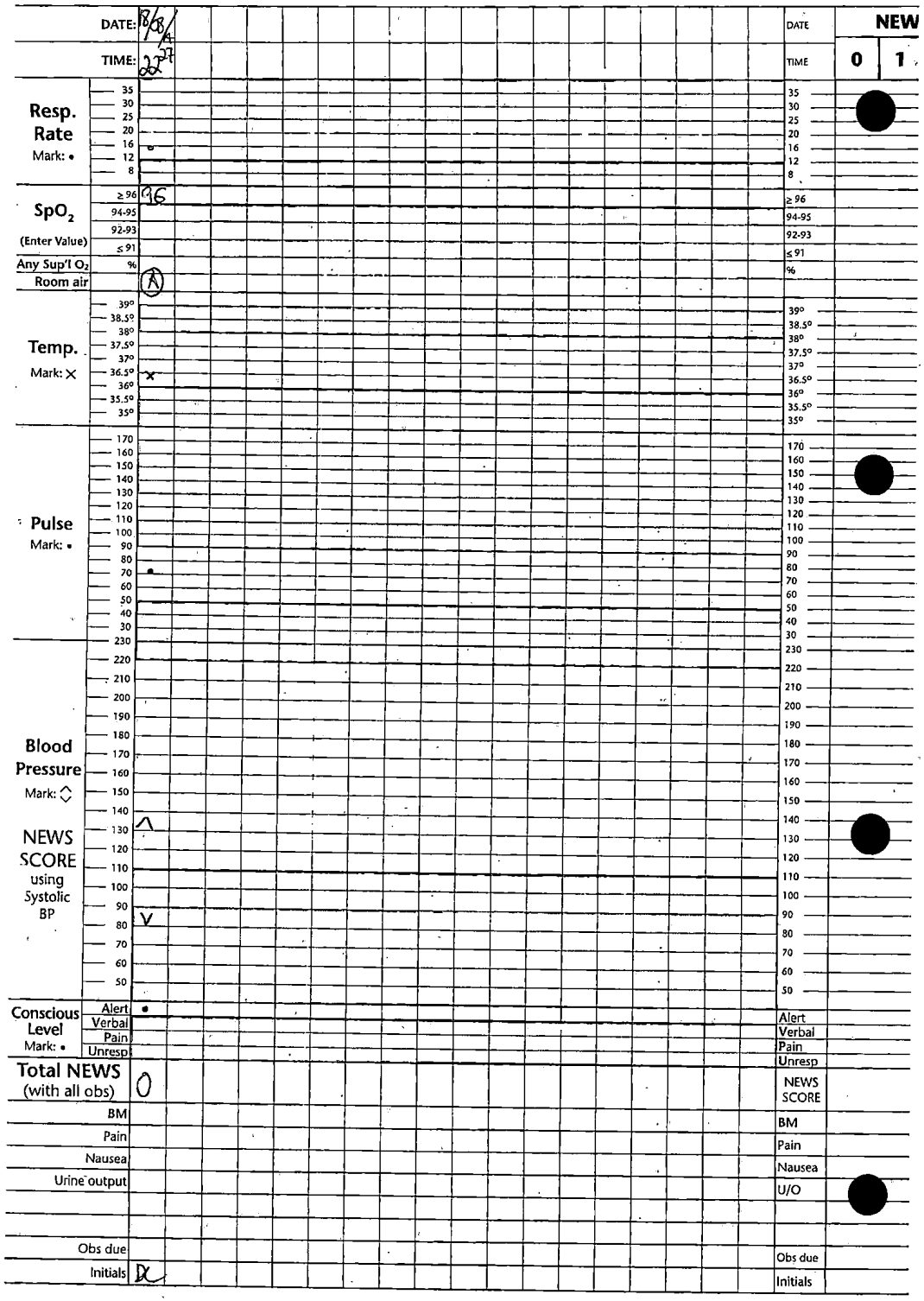
	Date	Ward
Admitted	18.03.14	A+E
Transferred		
Transferred		

Physiological Parameter	NEWS – NHS Early Warning Score						
	3	2	1	0	1	2	3
Respiration Rate	≤8		9-11	12-20		21-24	≥25
Oxygen Saturations	≤91	92-93	94-95	≥96			
Any Supplemental Oxygen		Yes		No			
Temperature	≤35.0°		35.1-36.0°	36.1-38.0°	38.1-39°	≥39.1°	
Pulse	≤40		41-50	51-90	91-110	111-130	≥131
Systolic BP	≤90	91-100	101-110	111-219			≥220
Conscious Level				A			V, P or U

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

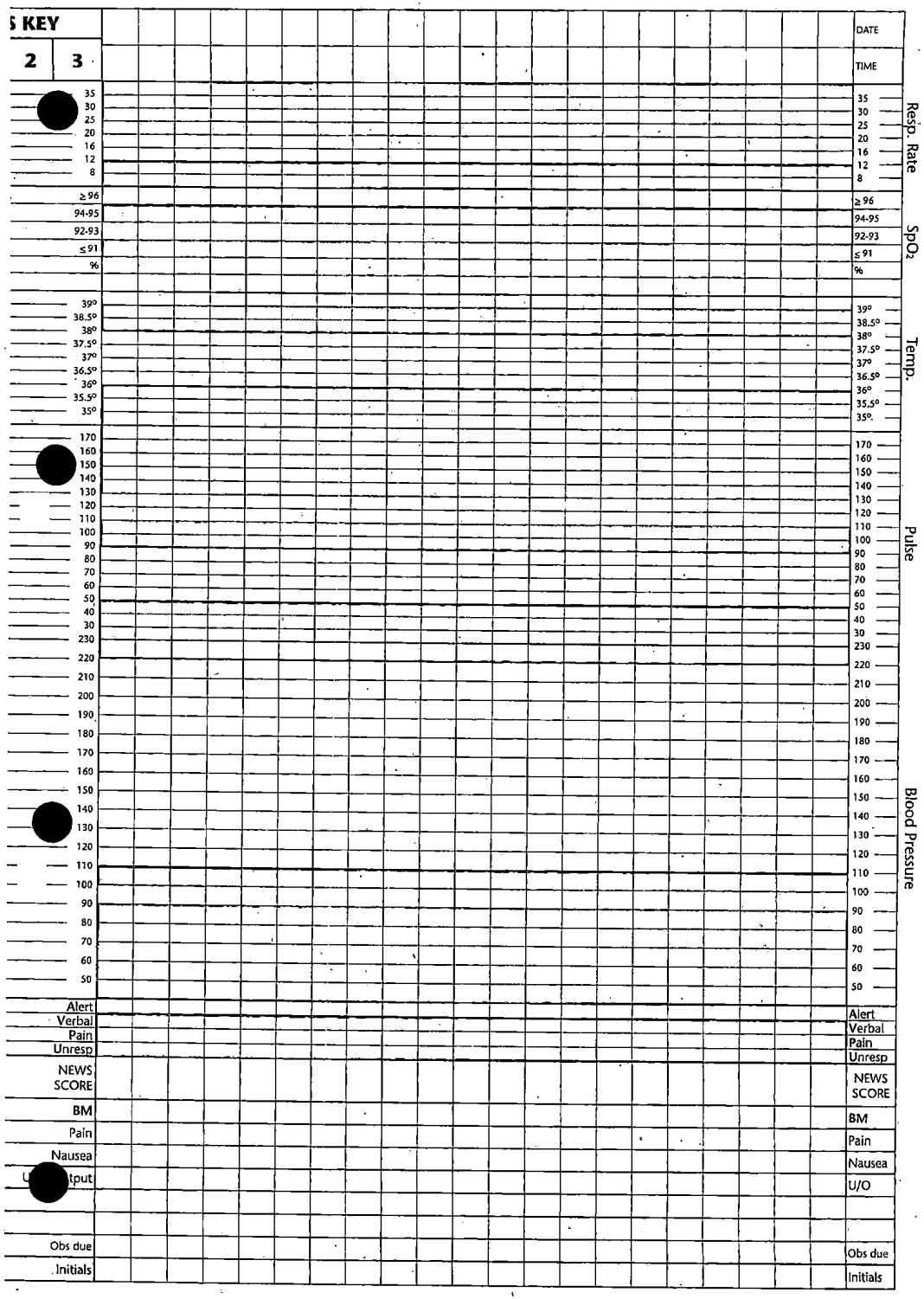
See NEWS Actions Reference Tool for local escalation policy

NEWS Score	Frequency of Monitoring	Clinical Response
0	Minimum 12 hourly	• Continue routine NEWS monitoring with every set of observations.
Aggregate 1- 4	Minimum 4 hourly	• Inform trained nurse. • Trained Nurse assessment: - Assess the patient - Review frequency of monitoring required - Assess need for escalation of clinical care and direct as appropriate.
Aggregate 5 or more or 3 in one parameter	Increased frequency to a minimum of 1 hourly	• Trained Nurse assessment. • Inform medical team caring for the patient. • Urgent assessment by a medical / surgical / nursing team with core competencies to assess acutely ill patients. • Consider level of monitoring required in relation to clinical care.
Aggregate 7 or more	Continuous monitoring of vital signs	• Trained Nurse to assess immediately. • Inform medical team caring for the patient – this should be at least senior medical staff level. • Emergency assessment by a clinical team with core competencies in the assessment of critically ill patients. This team will have critical care competencies and a practitioner/s with advanced airway skills and resuscitation skills. • Consider referral to high dependency or ITU.


DATE: 8/8/A
TIME: 22
Resp. Rate
Mark: •
35 30 25 20 16 12 8
SpO2
(Enter Value)
≥96 94-95 92-93 ≤91 %
96
Any Sup'l O2
Room air
A
Temp.
Mark: ×
39° 38.5° 38° 37.5° 37° 36.5° 36° 35.5° 35°
Pulse
Mark: •
170 160 150 140 130 120 110 100 90 80 70 60 50 40 30
Blood Pressure
Mark: ◇
NEWS SCORE using Systolic BP
230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50
Conscious Level
Mark: •
Alert
Verbal
Pain
Unresp
Total NEWS (with all obs)
0
BM
Pain
Nausea
Urine output
Obs due
Initials
DATE
TIME
NEW
0 1
NEWS SCORE
BM
Pain
Nausea
U/O
Obs due
Initials

Neurological Observations

| | | |


KEY
2
3
DATE
TIME
Resp. Rate
35
30
25
20
16
12
8
SpO2
≥ 96
94-95
92-93
≤ 91
%
Temp.
39°
38.5°
38°
37.5°
37°
36.5°
36°
35.5°
35°
Pulse
170
160
150
140
130
120
110
100
90
80
70
60
50
40
30
230
220
210
200
190
180
170
160
150
140
130
120
110
100
90
80
70
60
50
Blood Pressure
Alert
Verbal
Pain
Unresp
NEWS SCORE
BM
Pain
Nausea
U/O
Obs due
Initials

NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

4

Affix Label

CHI: 1203893450

Royal Alexandra Hospital

Total Att: **57**

12 Mth Att: **18**

Title: **MR**

WEIR **James**

DOB: **12/03/1989** Age: **25y** Sex: **Male**

3B MITCHELL AVENUE
Renfrew
Renfrewshire
PA4 8DT
01418480859

Next of kin: **GUTHERIE, Mary**
Relationship: **Mother**
01418480859

GP: **A Sunderland**
0141 207 7700

Attendance Date: **15/08/2014** Arrival Time: **17:43**

Registration Time: **17:43** Date of Incident: **15/08/2014**

Major Incident Desc:

Reason for Attendance: **exam**

Nursing Assessment

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

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

Presenting Complaint:

Observation Date: **15/08/2014 17:46** Nurse name: **Nurse Alistair Murphy**

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

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

Visual Acuity	
Left	
Right	
Corrected?	

GCS	
Eyes	
Motor	
Verbal	
Total	

rb

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

Nursing Notes: **? overdose. Patient not verbalising. Noone with patient. SAS state patient was threatening to hang self earlier. GCS8 in triage. History of mental health problems**

Child Assessment Questionnaire

E-Pacer PATIENT REPORT

Time 17:33 Date 15/08/2014

PATIENT AND INCIDENT DETAILS

Incident number	CR000515286.001
Name	JAMES ~~THOMAS~~ WEIR
Address	AS INCIDENT
Age	25
Date of birth	12/03/1989
Gender	Male
Incident location	3B MITCHELL AVENUE RENFREW
Incident post code	PA4 8DT
Incident type	EMG
Call received	15/08/2014, 16:29
Call passed	15/08/2014, 16:29
Crew mobile	15/08/2014, 16:30
Crew at scene	15/08/2014, 16:42
Crew left scene	15/08/2014, 17:07
Receiving hospital and department	RAHP Royal Alexandra - Paisley

PRIMARY SURVEY

RESPONSE

AVPU	Alert

AIRWAY

Airway assessment	Clear

BREATHING

Breathing rate	Normal
Respiratory rate	

CIRCULATION

Pulse rate	Fast
Most peripheral pulse found	Radial
Cap refill rate	
Skin colour	Normal
Skin texture	Dry

C-SPINE INJURY

Suspicion of CSI	No evidence of C-spine injury

AMPDS

Dispatch code	25B03	Threatening Suicide
Final code	31A01	Unconscious, Fainting episodes and alert, >35yrs, with no cardiac history

GCS

Final GCS eye opening	To pain
Final GCS verbal response	Nil
Final GCS motor response	Nil

VITAL SIGNS

hr : min	Pulse bpm	Pulse rhythm	Resp. rpm	BP mm Hg	Cap refill (secs)	Peak flow %	Blood sugar mm	Pain score	Temp °C	SpO2 %	GCS Total	NEWS	RTS	ECG	Sepsis
16:59	108	Reg	18	126 / 93	<2 secs	-	-	5.7	-	36.8	97	15	1	7.6	NSR	1
17:20	84	Reg	18	122 / 87	<2 secs	-	-	-	-	-	99	14	-	4.7	NSR	0
:	-	-	-	-/-	-	-	-	-	-	-	-	-	-	-	-	0

SEPSIS

Sepsis: Pneumonia	
Sepsis: UTI	
Sepsis: Other infection	
Sepsis: Abdo pain	
Sepsis: Diarrhoea	
Sepsis: Abdo distension	
Sepsis: Meningitis	
Sepsis: Cellulitis	
Sepsis: Septic arthritis	
Sepsis: Wound infection	
Sepsis: Infected indwelling device	

AMPLE

Allergies	Antibiotics
Other allergies	PENICILLAN
Medication	VELAFAXIN
Past history	PREVIOUS SELF HARM.
Last eaten	3 hrs
Events prior	? BROTHER CLAIMED P/T WAS ? GOING TO SELF HARM ? HANG HIMSELF

PATIENT HANDOVER

On arrival at scene	Standing
Scene removal	Walking
Transportation	Lying
Care delivery at hospital	Trolley
Time of handover	17:35

FINAL OBSERVATION AND COMMENTS

INITALLY P/T AGGITATED
CLAIMS TOOK ALCOHOL AND
WANTED TO SELF HARM
BASELINE OBS NORMAL
ENROUTE TO HOSP P/T ?
BECAME UNCONSCIOUS AND
FLACID REGECTED OP AIRWAY
THEN PROCEEDED TO VOMIT ?
COFFEE GROUNDS
RESPONDED TO VERBAL
STIMULI THEN NOT BUT EYES
WERE OPEN VOLENTARILY

Report ID	47224420-9e64-44d9-92d8-4dbd49741274

ONCE ONLY PRESCRIPTIONS (including Tetanus Prophylaxis)

Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Time of Administration	Signature	Given By

Out-of-Hours Psychiatric Nursing Service

NURSING ASSESSMENT

PATIENT DETAILS

Date 15.08.14.
Name JAMES WEIR.
Address 38 MITCHELL AVENUE. RENFREW.
Post Code PA4 8DT
DOB 12/03/89
Tel No 848 0859.

PiMS No
GP Name A SUNDERLAND.
GP Address

Known to Service: YES [X] NO [ ]

If so, Consultant/Keyworker Name:

Time Triaged (24Hr)

HR	MIN
22	45

JOHN FOREST – BROTHER.

Referrer: RAH A+E.
Assessor: C. GOLDIE & A. MM'GOLE

Time Visited

HR	MIN
22	45

Time Assessment/Contact Completed

HR	MIN
23	00

Venue Patient See At:

Home [ ] GEMS Clinic [ ] Other [ ] (Please specify):
A&E [X] Police [ ]
Hospital [ ]

(ing Worker)

HISTORY

1. Reason for Referral/History of Present Crisis:

Asked to assess, brought to A+E by ambulance and escorted by police following an incident at his brothers where he ~~attempted~~ threatened to hang self.

2. Relevant Psychiatric/Medical History/Present Medication:

Appointment today at RDS today which he missed.
Recently referred to CMHT by court liaison.

3. Mental State Assessment:

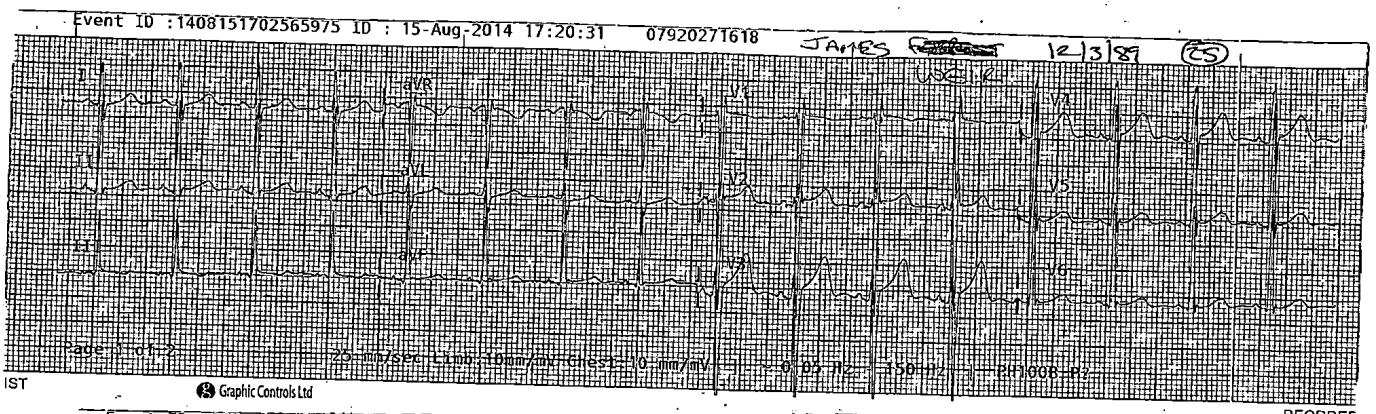
Will Include:	**Appearance/Behaviour, mood, Suicidal Ideation, Psychotic symptoms, Cognitive functioning, Thought process and insight**
May Include:	**Sleep, Appetite, Relevant substance abuse, Relevant personal history**

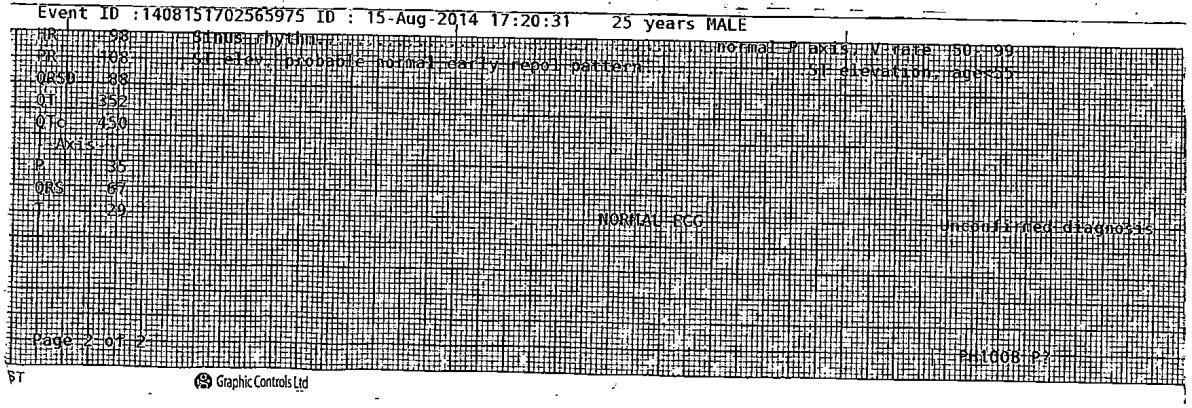
Claims that he attempted to hang himself with a T.V aerial wire by tying it around a pole in the bathroom at his brothers house.
Was in police custody on 12/08 for B&D of and G.B was called due to withdrawal
Court on Wednesday and referred to Paisley CMHT

Raped when 17 and that only stopped last year.. The offender has now been apprehended following another incident.
I need to be sectioned.
Wd 17 St John's Livingstone returned to Paisley in Feb. Childrens home in Johnstone age 14. started taking cannabis and alchol. Was in Haven in July for 6/52 and left of his own accord.

Uses heroin and crack cocaine. Last used on Monday prior to B.O.P. Unable to recall whether he has taken any illicit drugs. Pupils dilated. Eventually admitted drugs
Wants to stop alcohol and drugs. Uses as much as I want" injects heroin. Problematic for 2yrs. Drinks most days
Buckfast, cider vodka + beer. Shoplifts to fund this.
Relatively clean and tidy wearing a Tshirt and jogging bottoms. Good eye contact and fair rapport established.
Speech normal rate tone and volume and content appropriate
Mixed up as to what day it is but appears to be cognitively intact although not formally tested. Confusion in relation to drug.
Appears to be anxious and distressed when relaying his story of abuse.
No evidence of any psychotic symptoms or delusional thought disorder. Reports previous self harms.

Plans to attend Kendkerr college and has wishes to stop alcohol and drug use. Feels that he needs to "sort my life out".
In relation to the rape:
Reluctant to admit recent drug misuse and vague about how much he has taken.
Became angry during assessment, demanding to be "sectioned".
Unwilling to admit responsibility for his addiction.
We have advised James to contact RDS on Monday and we will inform them of our contact tonight


Event ID :14081517025659 75 ID : 15-Aug-2014 17:20:31 07920271618
JAMES
12/3/89
65
I
II
III
aVR
aVL
aVF
V1
V2
V3
V4
V5
V6
Page 1 of 2
25 mm/sec Limb 10mm/mV Chest 10 mm/mV
0.67 Hz
150 Hz
P1000B P?
IST
Graphic Controls Ltd
REORDER


Event ID :14081517025659 75 ID : 15-Aug-2014 17:20:31 25 years MALE
HR 98
PR 108
QRSD 88
QT 352
QTc 450
Axis
P 35
QRS 67
T 29
Sinus rhythm
ST elev, probable normal early repol pattern
normal P axis, V rate 50-99
ST elevation, age<30
NORMAL ECG
Unconfirmed diagnosis
Page 2 of 2
P1000B P?
ST
Graphic Controls Ltd

NEWS – National Early Warning Score

NHS
Greater Glasgow and Clyde

Name
Address

1203893450 12/03/1989
WEIR
James

CHI No.
DoB

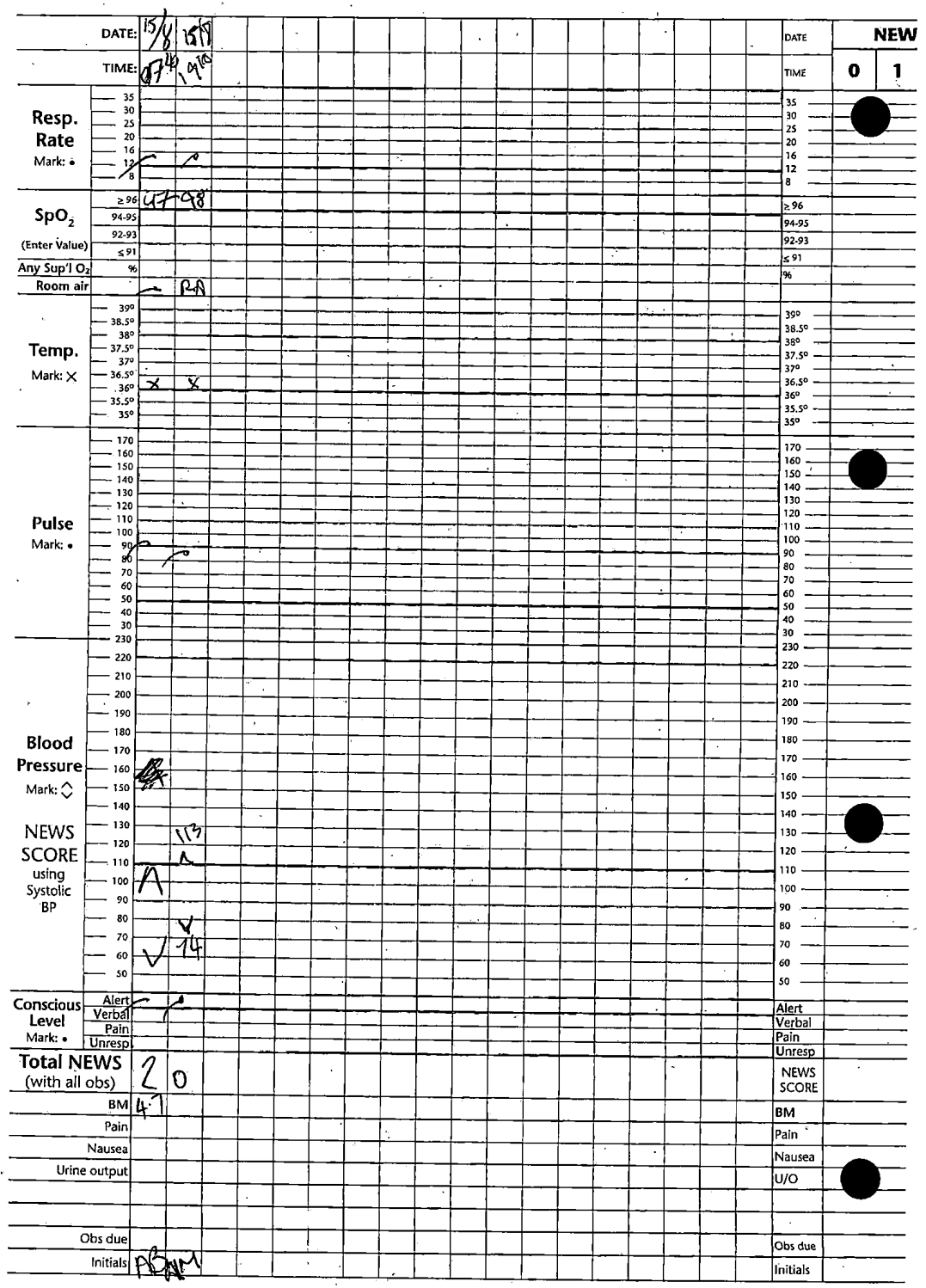
	Date	Ward
Admitted		
Transferred		
Transferred		

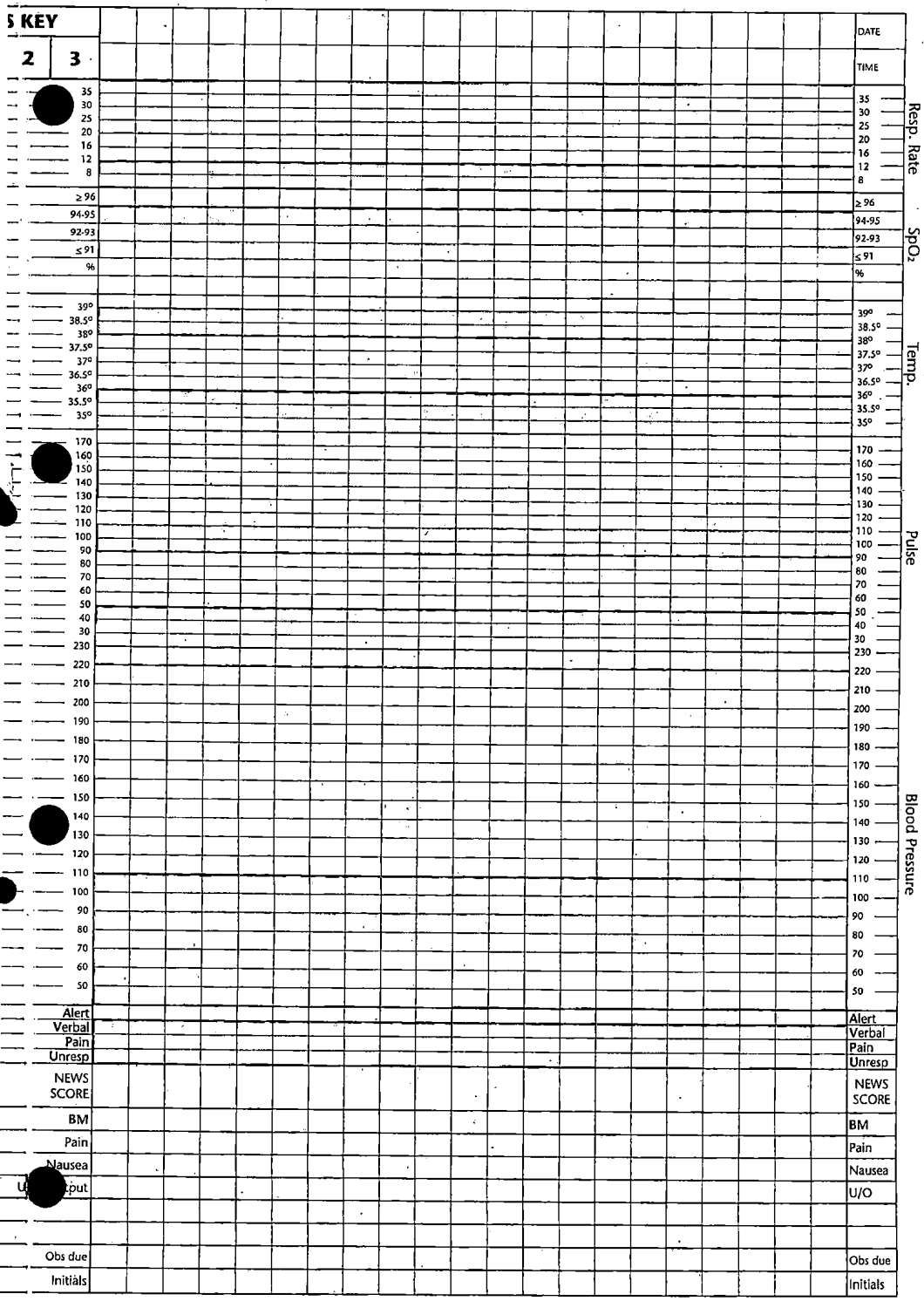
Physiological Parameter	NEWS – NHS Early Warning Score						
	3	2	1	0	1	2	3
Respiration Rate	≤8		9-11	12-20		21-24	≥25
Oxygen Saturations	≤91	92-93	94-95	≥96			
Any Supplemental Oxygen		Yes		No			
Temperature	≤35.0°		35.1-36.0°	36.1-38.0°	38.1-39°	≥39.1°	
Pulse	≤40		41-50	51-90	91-110	111-130	≥131
Systolic BP	≤90	91-100	101-110	111-219			≥220
Conscious Level				A			V, P or U

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

See NEWS Actions Reference Tool for local escalation policy

NEWS Score	Frequency of Monitoring	Clinical Response
0	Minimum 12 hourly	• Continue routine NEWS monitoring with every set of observations.
Aggregate 1- 4	Minimum 4 hourly	• Inform trained nurse. • Trained Nurse assessment: - Assess the patient - Review frequency of monitoring required - Assess need for escalation of clinical care and direct as appropriate.
Aggregate 5 or more or 3 in one parameter	Increased frequency to a minimum of 1 hourly	• Trained Nurse assessment. • Inform medical team caring for the patient. • Urgent assessment by a medical / surgical / nursing team with core competencies to assess acutely ill patients. • Consider level of monitoring required in relation to clinical care.
Aggregate 7 or more	Continuous monitoring of vital signs	• Trained Nurse to assess immediately. • Inform medical team caring for the patient – this should be at least senior medical staff level. • Emergency assessment by a clinical team with core competencies in the assessment of critically ill patients. This team will have critical care competencies and a practitioner/s with advanced airway skills and resuscitation skills. • Consider referral to high dependency or ITU.


DATE:
TIME:
Resp. Rate
Mark: •
SpO2
(Enter Value)
Any Sup'l O2
Room air
Temp.
Mark: ×
Pulse
Mark: •
Blood Pressure
Mark: ◇
NEWS SCORE using Systolic BP
Conscious Level
Mark: •
Alert
Verbal
Pain
Unresp
Total NEWS (with all obs)
BM
Pain
Nausea
Urine output
Obs due
Initials
NEW
0
1


S KEY
2
3
DATE
TIME
Resp. Rate
35
30
25
20
16
12
8
SpO2
≥ 96
94-95
92-93
≤ 91
%
Temp.
39°
38.5°
38°
37.5°
37°
36.5°
36°
35.5°
35°
Pulse
170
160
150
140
130
120
110
100
90
80
70
60
50
40
30
230
220
210
200
190
180
170
160
150
140
130
120
110
100
90
80
70
60
50
Blood Pressure
Alert
Verbal
Pain
Unresp
NEWS SCORE
BM
Pain
Nausea
U/O
Obs due
Initials

Neurological Observations

| | | |

Emergency Department Nursing Documentation

NHS Greater Glasgow and Clyde

Patient Addressograph Label
1203893450 12/03/1989
WEIR
James

Presenting Complaint: Suicidal

Date and Time: 15/8/14 1800

Named Nurse(s): ABorland

Patient preparation (Please tick when completed)	Initials: AB	Communication (Please tick when completed)	Initials: AB
Prepare patient for examination	☑	Communication Aids (spectacles / hearing aid)	☐
Provide blankets if required	☑	Relatives present? Police	☑
Clothing bagged, labelled and stored under trolley	☑	Relatives / NOK informed	☐
Name-band (if required) Penicillin ~~ALLERGY~~	☑	Interpreter required	☐
		Telephone interpretation required	☐

Observations and Investigations (Please tick when completed)		Initials:	
Vital Signs recorded on NEWS chart and NEWS score recorded. Record Pain, blood sugar and neuro obs on NEWS chart if appropriate.	☑	IV Cannula (if required) dated and timed	☐
Peak Flow 1. 2. 3.	☐	Blood samples taken	☐
12 Lead ECG	☐	Urinalysis and Specimen if indicated *Results:*	☐
Cardiac Monitoring	☐		
X-rays performed	☐	HCG specimen if indicated +ve ☐ -ve ☐ Strip Lot no:	☐
Other: please add	☐	Weight:	☐

Screening Tools (Please circle or tick as appropriate)		Initials:	
SEPSIS risk? SIRS Criteria 2 or more and suspicion of infection	Y / N	**Preliminary Pressure Ulcer Risk Assessment** The patient can reposition themselves whilst in the department?	Y / N
AMT 4 (if >65 years) SCORE	/4	There is no reported skin damaged other than presenting trauma?	Y / N
At risk of falls? (clinical judgement) (consider alcohol, mobility, age, illness, cognitive impairment etc). *If at risk complete risk assessment*	Y / N	The person is fully continent? *If NO to any of the above initiate Waterlow risk assessment (within 4 hrs)*	Y / N
Mental Health Triage Assessment	Y / N	**Waterlow Score** *If >10 commence Active Care*	☐
Child Protection considered (in line with policy)	Y / N	**Active Care** (clinical judgement) (include all trolley patients at risk of pressure ulcers and all trolley patients in department for >4hrs) *Record on Active Care Chart*	☐
GMAWS	Y / N	Pressure damage identified on arrival in ED is documented in clinical notes	☐
Swallow test (If CVA/stroke)	Y / N	Grade 3 or 4 Pressure Ulcers are reported on DATIX	☐

Pause for Transfer (Please tick when completed)		Tick when completed	N/A	Notes
	Relatives informed	☐	☐	Information on discussion with relatives
	Cannula dated and timed	☐	☐	
	Name band	☐	☐	
	AMT4	☐	☐	
	NEWS chart	☐	Always	
Prescriptions signed	Infusions	☐	☐	
	Drugs	☐	☐	
	Fluids	☐	☐	
	GMAWS	☐	☐	
	Belongings (including patient's medications)	☐	Always	Please note here if any other tasks required prior to transfer
	Bed requested, accepted and ward informed	☐	Always	
	Notes: medical notes, GP letter, PRF	☐	Always	
Investigations	CXR reviewed	☐	☐	
	ECG reviewed	☐	☐	Print name
	Bloods sent	☐	☐	
	Bloods reviewed	☐	☐	
	Patient on O_2: cylinder checked	☐	☐	
	Patients requiring analgesia: sufficient	☐	☐	

Patient Addressograph Label

Pause for Discharge (Please tick when completed)	Tick when completed	N/A	Notes
Advice leaflets given	☐	☐	Information on discussion with relatives
Belongings (including patient's medications)	☐	Always	
New medications explained	☐	☐	
Cannula removed	☐	☐	
Relatives aware of discharge	☐	☐	Please note here if any other tasks required prior to discharge
Social/ Support Services required and contacted	☐	☐	
SAS transport required and ref no	☐	☐	Print name
Other means of transport arranged by nurse	☐	☐	

Nursing Notes

Date and Time		Print Name and Signature
15/8/16 - 1805	Into room & prepared police in attendance	
1925	Referred to IHTT. Day shift unable to assess. To refer again at 20^{00}.	AB
		Okan

Patient Addressograph Label

Nursing Notes

Date and Time		Print Name and Signature

Emergency Department - Active Care

I have evaluated and deemed that the frequency of care delivery over the next work shift, based on the patient's most critical need should be every:

(Please circle) ½ hour 1hour 2 hours

Signed ..... Name .....

Patient Addressograph Label

			Time							
	1.	PAIN: Assess and address If in pain inform registered nurse Y or N/A								
S	2.	SKIN INSPECTION A. Pressure areas checked:								
		B. Redness (R) / Discolouration (D) / Pressure Ulcer (PU)								
K	3.	KEEP MOVING: A. Have you moved or walked Y / N / I (independent)								
		B. Trolley Right side (30° tilt) – R Left Side (30° tilt) – L Back– B								
		C. Chair Assist to walk, stand or tilt (W /ST/ T)								
I	4.	ELIMINATION: Do you need the toilet? I = Independent A = Assistance given IC = patient incontinent of urine/faeces								
N	5.	FOOD, FLUIDS AND NUTRITION: Is the patient nil by mouth? Y / N (consider mouth care)								
		Encourage the patient to drink? (If appropriate) Y / N / N/A								
		Food, snack or supplement taken? (If appropriate) Y / N / N/A								
	6.	ENVIRONMENT: Is the patient able to call for assistance? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the trolley in lowest position?								
	7.	INFORMATION: Ask: Is there anything else I can help you with? Inform patient of the time of return.								
	8.	ESCALATION: Escalate any issues to the Registered Nurse / Dr Y / N/A								
		Nurse Initials								

USE FOLLOWING CODE	Specialist Pressure Redistributing equipment	Variations			
V = Variant I = Independent NT = No thanks	☐ Repose Mattress ☐ Moving and handling aids ☐ Other:	Time	No.	Variation	Signed

Waterlow Pressure Area Risk Assessment

Build/Weight		Skin Type/Visual Risk Areas		Sex/Age		Special Risks - Tissue Malnutrition	
Average (BMI 20-24.9)	0	Healthy	0	Male	1	Multiple organ failure/ Terminal cachexia	8
Above Average (BMI 25-29.9)	1	Tissue Paper (thin/fragile)	1	Female	2		
Obese (BMI > 30)	2	Dry (appears flaky)	1	14-49	1	Single organ failure	5
Below Average (BMI < 20)	3	Oedematous (puffy)	1	50-64	2	Peripheral Vascular Disease	5
Continence		Clammy /pyrexia	1	65-74	3	Anaemia = Hb < 8	2
Complete/Catheterised	0	Discoloured (brusing/mottled)	2	75-80	4	Smoking	1
Incontinent urine	1			81+	5	Neurological Deficit	
Incontinent faeces	2	Broken (established ulcer)	3	Nutritional Element		Diabetes/MS/CVA Motor or sensory paraplegia (Max 6)	4-6
Doubly Incontinent (urine and faeces)	3	Mobility		Unplanned weight loss in past 3-6 months < 5% Score 0 5-10% Score 1 > 10% Score 2			
		Fully mobile	0				
Special Risks – Surgery/Trauma		Restless/Fidgety	1			Special Risks - Medication	
On table > 6 hours	8	Apathetic (sedated/depressed/ reluctant to move)	2			Cytotoxic, anti-inflammatory, long term/high dose steroids (Max 4)	4
Orthopaedic / below waist/Spinal (up to 48 hrs post-op)	5			BMI > 20 Score 0 BMI 18.5-20 Score 1 BMI < 18.5 Score 2			
On table > 2 hours (up to 48 hrs post op)	5	Bed bound (unconscious/unable to change position/traction)	4			Risk Score 10+ = 'At risk' 15+ = 'High Risk' 20+ = 'Very High Risk'	
		Chair Bound	5	Patient acutely ill or no nutritional intake > 5 days	2		

Patient's Initial Waterlow Score = If Score ≥10 Complete the Adapted Waterlow Pressure Area Risk Assessment Chart

WEIR, JAMES ID: 1203893450 15-Aug-2014 1 46 ROYAL ALEXANDRA HOSPITAL

12-Mar-1989
Male Caucasian
Room:
Loc: 800 Opt

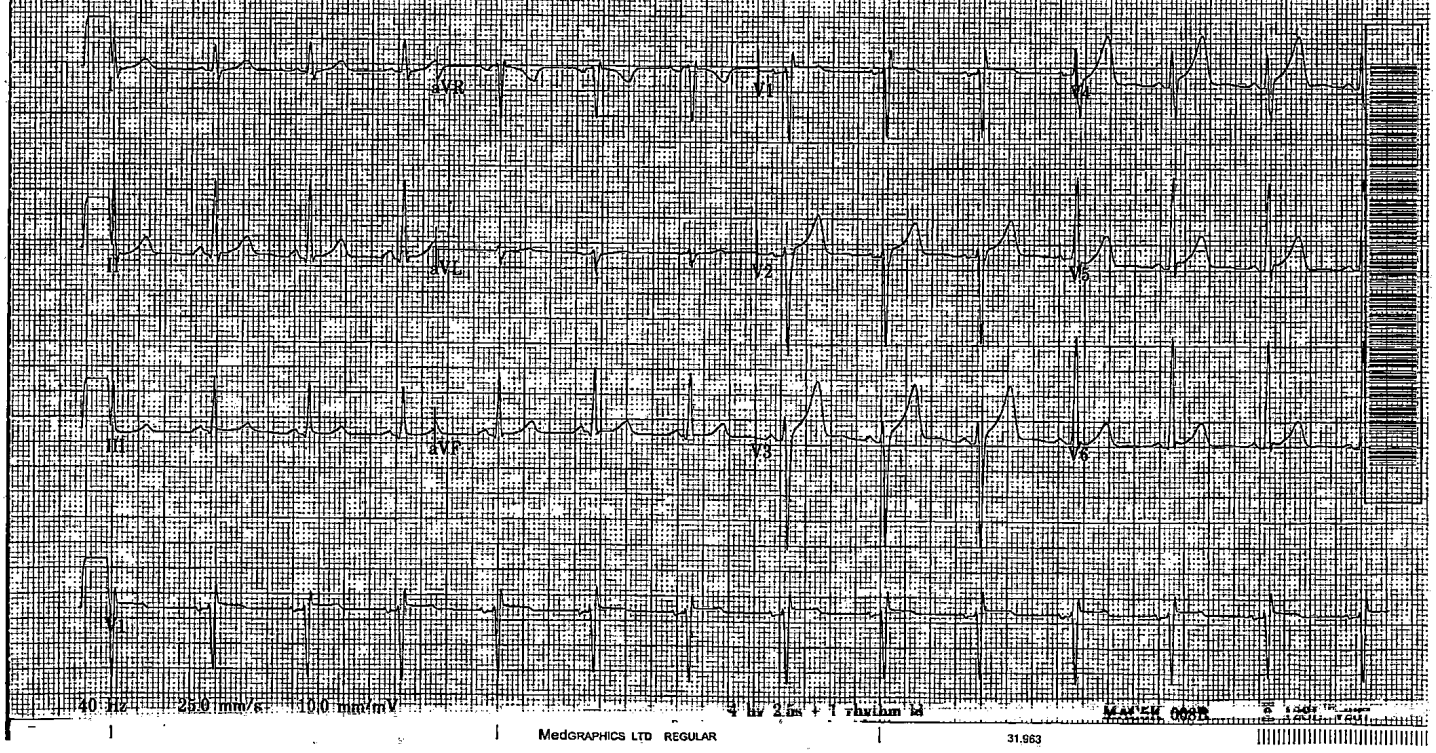
Vent. rate 80 bpm
PR interval 122 ms
QRS duration 88 ms
QT/QTc 376/433 ms
P-R-T axes 67 73 51

Normal sinus rhythm
RSR' or QR pattern in V1 suggests right ventricular conduction delay
ST elevation, probably due to early repolarization
Borderline ECG

Technician:
Test ind.:

Referred by:

Unconfirmed



40 Hz 25.0 mm/s 10.0 mm/mV 4 by 2.5 + 1 rhythm ld

MedGRAPHICS LTD REGULAR

31.963

Date	CLINICAL NOTES
	Seen by (Dr) Adams Time seen 1915

28 GENTLEMAN

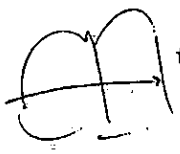
CHRONIC DEPRESSION. SELF HARM. PREVIOUS OVERDOSES.
CURRENTLY IVDU + ETOH x3
DH PREVIOUSLY ON VENLAFAXINE. NO KNOWN ALLERGY
SH CURRENTLY LIVING WITH PARTNER
DENIES DRUG. SMOKES 10 DAY

ADMITTED ON WEDNESDAY EVENING WITH ETOH/OPIATE WITHDRAWAL.
D/C HOME YESTERDAY
CAME FROM SOUTH HX - AUNT'S DAY BACK BY ANOTHER NURSE.
CHRONICALLY LOW MOOD SINCE TEEN + SUICIDAL IDEATION
PREVIOUSLY KNOWN TO PSYCH SERVICES
USED HEROIN AS NORMAL
DENIES ANY OVERDOSE TODAY OR ANY OTHER RECREATIONAL DRUGS.
2-3 BEERS ALSO TODAY
ATTEMPTED TO HANG HIMSELF IN BATHROOM LAST NIGHT
TIED CABLE AROUND NECK AND KNEE.
- CABLE HOWEVER WOULD NOT HOLD WEIGHT
BROTHER HEARD THUD + CALLED 999

ECG - EARLY REPOLARISATION

ECS IS COOPERATIVE
ADAMANT WANTS TO DIE.
ORS (N) ANTIDEPRESSANT BM 5.7
C SCARS NOW HEALED

ALLEGATIONS AROUND NECK (STRANGULATION).





CVS INTACT.
NEUROLOGICALLY INTACT THROUGHOUT

CONTINUE WISH TO DIE "I HAVE NOTHING TO LIVE FOR"
"JUST WANTS TO GO HOME TO DIE"

PSYCH REVIEW. DISCHARGED HOME 1910
ADVISED CALL BACK OOH TEAM 2000

[signature] 30/7/15

Date	CLINICAL NOTES
CN 22.45	Asked to assess this 25 yr old male who was brought to A+E by ambulance accompanied by police. See assessment attached. CNol

Discharge Codes (Please CIRCLE)					Discharge date	
1. Admission	2. Discharge	3. Refer to GP	4. Transfer to other (see below)			
5. Died	6. Refer to OP Clinic (see below)		7. Irregular Discharge	8. D.O.A.	Discharge time	

Ward number (if admitted):	Transfer to hospital:	Consultant If admitted):

Follow up	Arranged			Not arranged			To be arranged	
Clinic referred to	A&E	Hand injury	Fracture	Pop Check	Medical	Surgical	ENT	Others (specify):

Discharge Prescription Packs

Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Frequency	Signature	Given By

Designed by Medical Illustration Services ref 243836

15

NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

CHI: 1203893450

Royal Alexandra Hospital

Total Att: 55

12 Mth Att: 16

Title: MR

WEIR **James**

DOB: **12/03/1989** Age: **25y** Sex: **Male**

3B MITCHELL AVENUE
Renfrew
Renfrewshire
PA4 8DT
01418480859

Next of kin: **GUTHERIE, Mary**
Relationship: **Mother**
01418480859

GP: **A Sunderland**
0141 314 4645

Attendance Date: **23/07/2014** Arrival Time: **20:35**

Registration Time: **20:35** Date of Incident: **23/07/2014**

Major Incident Desc:

Reason for Attendance: **mental health issues**

Affix Label

Nursing Assessment

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

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

Presenting Complaint:

Observation Date: **23/07/2014 20:49** Nurse name: **Nurse Michelle Mccord**

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

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

Visual Acuity	
Left	
Right	
Corrected?	

GCS	
Eyes	
Motor	
Verbal	
Total	

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

Nursing Notes: **depression alcohol excess not coping with day to day activity not suicidal ..seeking support with alcohol wothdrawl has ben drinking today**

Child Assessment Quest

	YES	NO
Previous attendance (cons		
History variable between a		
Examination not compatit		
Delay in presentation		
Fracture/head injury or sig		

Disc

X-Ray and Other R ... admitted)

Incident number	CR000465259.001
Name	JAMES WEIR
Address	3 B MITCHELL AVE RENFREW
Age	25
Date of birth	12/03/1989
Gender	Male
Incident location	89 GLENIFFER ROAD RENFREW
Incident post code	PA4 0QX
Incident type	EMG
Call received	23/07/2014, 19:53
Call passed	23/07/2014, 19:53
Crew mobile	23/07/2014, 19:54
Crew at scene	23/07/2014, 19:59

PRIMARY SURVEY

RESPONSE	
AVPU	Pain
AIRWAY	
Airway assessment	Clear
BREATHING	
Breathing rate	Normal
Respiratory rate	
CIRCULATION	
Pulse rate	Fast
Most peripheral pulse found	Radial
Cap refill rate	
Skin colour	Normal
Skin texture	Dry
C-SPINE INJURY	
Suspicion of CSI	No evidence of C-spine injury
PATIENT CONSENT	
Patient consent	Treatment benefits explained, Risks of condition explained, Risk of refusal explained, Capacity to understand risks and treatment, Advice given to patient

AMPDS

Dispatch code	31D03	Unconscious or Fainting - Not Alert
Final code	31D02	Unconscious, effective breathing

GCS

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

VITAL SIGNS

Time hr : min	Pulse bpm	Pulse rhythm	Resp. rpm	BP mm Hg	Cap refill (secs)	Peak flow %	Blood sugar mmol / l	Pain score	Temp °C	SpO2 %	GCS Total	NEWS	RTS	ECG	Sepsis
20:00	117	Reg	19	123 / 73	<2 secs	-	5.1	-	36.3	96	15	5	7.6	-	1

SEPSIS

Sepsis: Pneumonia
Sepsis: UTI
Sepsis: Other infection
Sepsis: Abdo pain
Sepsis: Diarrhoea
Sepsis: Abdo distension
Sepsis: Meningitis
Sepsis: Cellulitis
Sepsis: Septic arthritis

Date Given	DRUG (Bi	ature	Given By

Date	CLINICAL NOTES

Pupil reaction	Normal	Normal

AMPLE

Allergies	Antibiotics
Other allergies	
Medication	VARIOUS
Past history	DEPRESSION,T2 DIABETIC,
Last eaten	>5 hrs
Events prior	PT FOUND PASSED OUT IN A GARDEN, PT ROUSED WITH VOICE AND PAINFULSTIMULI. PT SAYS HE HAS BEEN DRINKING ALOT OF ALCOHOL TODAY.

SUBSTANCES AFFECTING CONDITION

Alcohol

PATIENT HANDOVER

On arrival at scene	Lying
Scene removal	Walking
Transportation	Seated
Care delivery at hospital	Walking
Time of handover	20:45

ETHNICITY

Ethnicity White	British
White Other	
Not stated	

FINAL OBSERVATION AND COMMENTS

PT STATES HE WANTS HELP WITH THE WAY HE IS FEELING, PT SAYS HE HAS ASKED FOR HELP BUT FEELS HE IS NOT GETTING ANY, PT WAS AT RAH 3 MONTHS AGO ASKING FOR HELP WITH HIS DEPRESSION. PT REMOVED BP CUFF BEFORE END PR

Discharge Codes (Please CIRCLE)					Discharge date	
1. Admission	2. Discharge	3. Refer to GP	4. Transfer to other (see below)			
5. Died	6. Refer to OP Clinic (see below)		7. Irregular Discharge	8. D.O.A.	Discharge time	

Ward number (if admitted):	Transfer to hospital:	Consultant if admitted):

Follow up	Arranged	Not arranged	To be arranged

Clinic referred to	A&E	Hand injury	Fracture	Pop Check	Medical	Surgical	ENT	Others (specify):

Discharge Prescription Packs

Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Frequency	Signature	Given By

Designed by Medical Illustration Services ref 243836

Date	CLINICAL NOTES
	Seen by (Dr) Commen Time seen

- Brought by police.
- has been drinking all day
- still drinks.
- smells heavily of alcohol.
- → too intoxicated to be assessed.
- → Removed by Police.

Commen
STL.

Glasgow Emergency Departments
Mental Health Triage and Risk Assessment

this side to be completed by triage nurse

1203893450
na WEIR 12/03/1989
James
Do
CHI

1. Triage observations

document only physiological measurements

GCS	BM	HR	BP	RR	SaO^2	Temp

accompanied by

name relations of particular concerns

Blue joggers.
White trainers.
Silver jacket
Size 12"

briefly describe patients attending alone (they may leave before assessment)

2. Outline of presentation

tick all those categories which apply and provide a brief summary

overdose – will require medical assessment	
self-injury – will require wound management	
other mental health presentation	✓

Depression - anger issues

3. Initial presentation, appearance and behaviour

respond yes or no to each question

Is the patient violent, aggressive or threatening?	Yes		(No)
Is the patient obviously distressed, markedly anxious or highly aroused?		(Yes)	No
Is the patient quiet and withdrawn?		(Yes)	No
Do you think the patient is behaving inappropriately to their situation?		Yes	(No)
Do you think the patient presents an immediate risk to you, to others, or to themselves?	(Yes)		No
Do you think the patient is likely to abscond prior to assessment?	(Yes)		No
Do you think the patient's presentation suggests either delusions or hallucinations?*	Yes		(No)
Do you think the patient's presentation suggests they feel their actions are being controlled?	Yes		(No)
Are you aware of a history of violence or self harm?		Yes	(No)
Are you aware of a history of mental health problems or psychiatric illness?		Yes	No

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

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

other patients can be categorized as → **Moderate Risk**

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

4. Triage Risk Assessment

indicate your initial category of risk, reviewing above and selecting another if more risks

High / Moderate / Low risk

of self-harm/violence/absconding in department

Triage Category		high risk – supervised *and* in the department moderate risk – supervised *or* in the department low risk – can be asked to wait if necessary

5. Immediate management

e.g. IV toxbase information, stat paracetamol overdose, drugs misused, non-urgent referrals

Patient location, supervised by...	Rm 18		
blood sample time?		toxbase information printed?	

print name M. McCord

signature

date 23/7/14 time 2047

Emergency Department Mental Health Assessment

this should be completed by medical staff

outline of current presentation and precipitating factors

previous mental health problems, self harm, addictions, medication etc

other relevant information; relationships, finances, employment, housing, physical health, childcare etc

Appearance	Behaviour	Speech
Mood	Thought	Insight

Is the patient a carer for a child or dependent adult?	Y/N
Is there a child protection concern?	Y/N

Risk assessment

based on clinical assessment, indicate category of risk of further episode of self harm in the short term (48 hrs), considering any protective as well as precipitating factors

High / Moderate / Low

negative responses in the 4 categories highlighted may allow patients to be categorised as low risk

Suicide Risk Factors	yes	no	unknown
male gender	y	n	u
age <18 or >65	y	n	u
depression	y	n	u
alcohol or drug use	y	n	u
separated, widowed, divorced	y	n	u
suicide plan/concealment	y	n	u
evidence of psychosis	y	n	u
ongoing suicial intent	y	n	u
lack of social support	y	n	u
chronic physical illness/pain	y	n	u
family history of suicide	y	n	u
family concern about risk	y	n	u
disengaged/poor compliance	y	n	u
unemployed or retired	y	n	u
access to lethal means of harm	y	n	u
previous violent methods	y	n	u
history/current overdose	y	n	u
prior psychiatric treatment	y	n	u
current psychiatric treatment	y	n	u
current use of benzodiazepines	y	n	u

Summary and plan for further assessment

referral to liaison psychiatry duty doctor, CPN service, CMHT, crisis/acute service etc

Summary	
Service referred to	time of referral

for patients awaiting assessment, indicate where they should wait, and who will supervise them; for patients to be transferred, indicate means of travel and anyone who will accompany them; for other outcomes, indicate the follow-up plan and name and relationship of the carers informed of this plan.

print name _____

signature _____

date _____ time _____

NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

Name
Address

1203893450 12/03/1989
WEIR
James

CHI No.
DoB

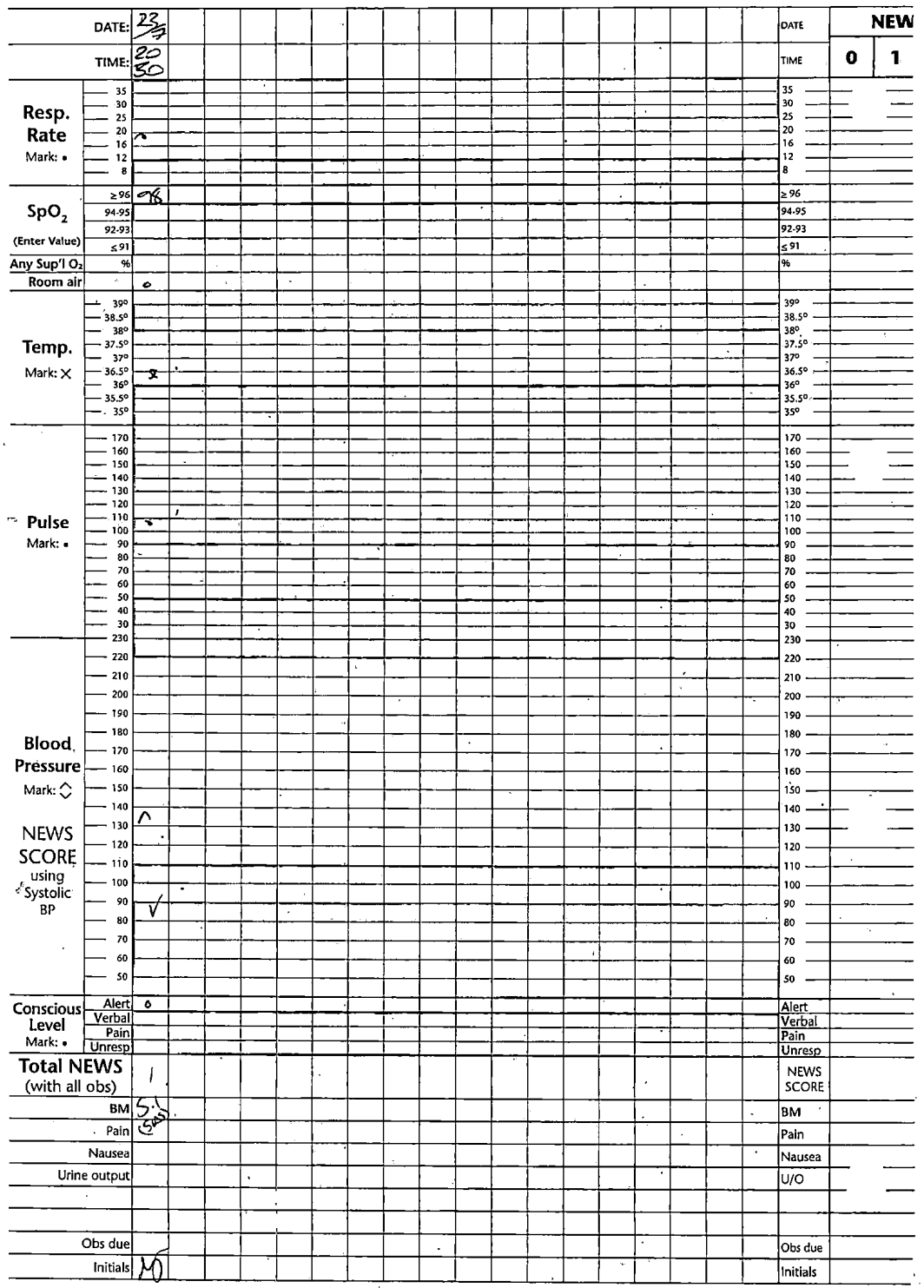
	Date	Ward
Admitted		
Transferred		
Transferred		

Physiological Parameter	NEWS – NHS Early Warning Score						
	3	2	1	0	1	2	3
Respiration Rate	≤8		9-11	12-20		21-24	≥25
Oxygen Saturations	≤91	92-93	94-95	≥96			
Any Supplemental Oxygen		Yes		No			
Temperature	≤35.0°		35.1-36.0°	36.1-38.0°	38.1-39°	≥39.1°	
Pulse	≤40		41-50	51-90	91-110	111-130	≥131
Systolic BP	≤90	91-100	101-110	111-219			≥220
Conscious Level				A			V, P or U

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

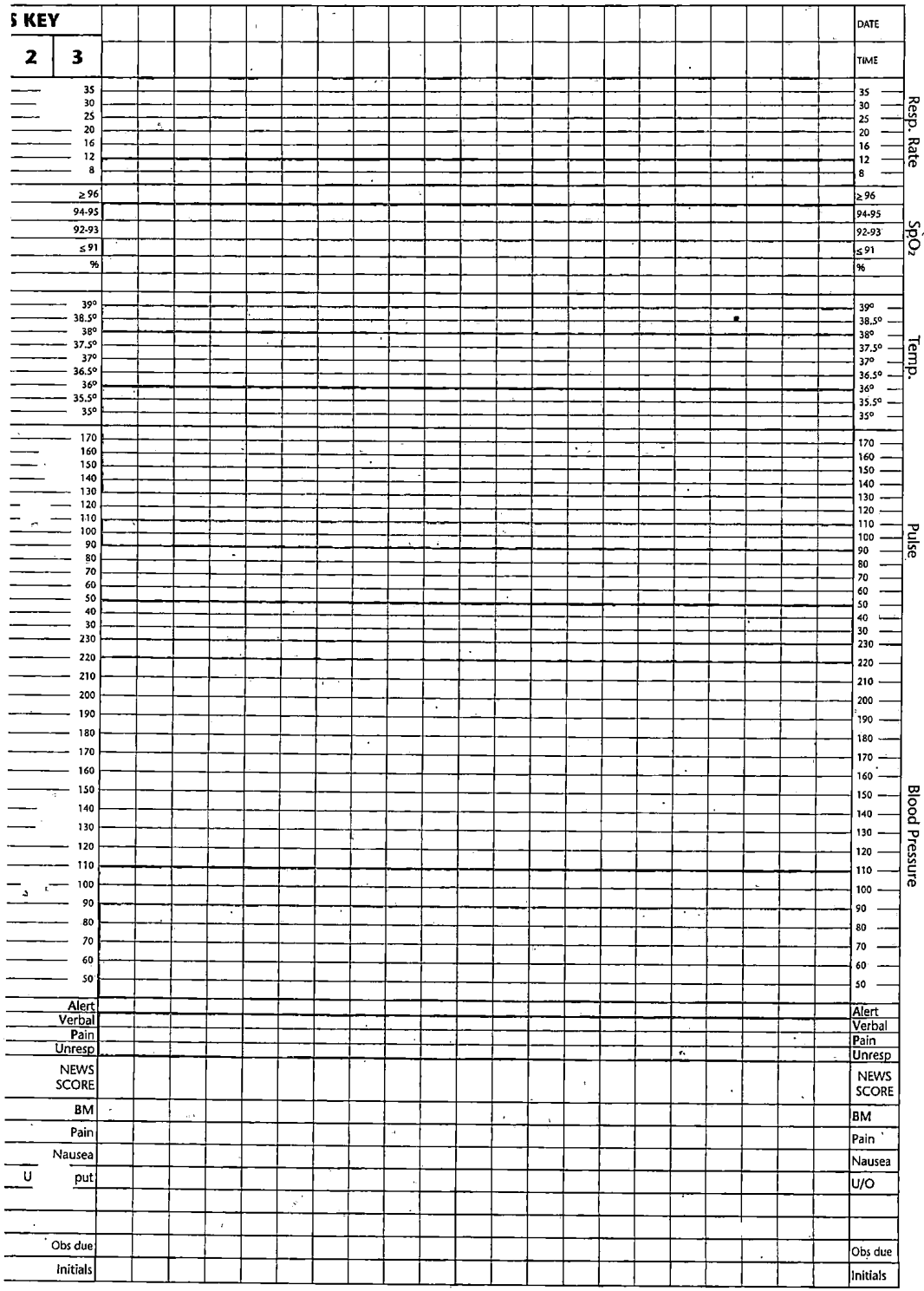
See NEWS Actions Reference Tool for local escalation policy

NEWS Score	Frequency of Monitoring	Clinical Response
0	Minimum 12 hourly	• Continue routine NEWS monitoring with every set of observations.
Aggregate 1- 4	Minimum 4 hourly	• Inform trained nurse. • Trained Nurse assessment: - Assess the patient - Review frequency of monitoring required - Assess need for escalation of clinical care and direct as appropriate.
Aggregate 5 or more or 3 in one parameter	Increased frequency to a minimum of 1 hourly	• Trained Nurse assessment. • Inform medical team caring for the patient. • Urgent assessment by a medical / surgical / nursing team with core competencies to assess acutely ill patients. • Consider level of monitoring required in relation to clinical care.
Aggregate 7 or more	Continuous monitoring of vital signs	• Trained Nurse to assess immediately. • Inform medical team caring for the patient – this should be at least senior medical staff level. • Emergency assessment by a clinical team with core competencies in the assessment of critically ill patients. This team will have critical care competencies and a practitioner/s with advanced airway skills and resuscitation skills. • Consider referral to high dependency or ITU.


DATE: 23/3
TIME: 2030
Resp. Rate
Mark: •
35
30
25
20
16
12
8
SpO2
(Enter Value)
≥ 96
94-95
92-93
≤ 91
Any Sup'l O2
%
Room air
Temp.
Mark: ×
39°
38.5°
38°
37.5°
37°
36.5°
36°
35.5°
35°
Pulse
Mark: •
170
160
150
140
130
120
110
100
90
80
70
60
50
40
30
Blood Pressure
Mark: ◇
230
220
210
200
190
180
170
160
150
140
130
120
110
100
90
80
70
60
50
NEWS SCORE using Systolic BP
Conscious Level
Mark: •
Alert
Verbal
Pain
Unresp
Total NEWS (with all obs)
1
BM
5.1
Pain
Nausea
Urine output
Obs due
Initials
DATE
TIME
NEW
0
1
NEWS SCORE
BM
Pain
Nausea
U/O
Obs due
Initials

Neurological Observations

| | | |


KEY
2
3
DATE
TIME
Resp. Rate
35
30
25
20
16
12
8
SpO2
≥ 96
94-95
92-93
≤ 91
%
Temp.
39°
38.5°
38°
37.5°
37°
36.5°
36°
35.5°
35°
Pulse
170
160
150
140
130
120
110
100
90
80
70
60
50
40
30
Blood Pressure
230
220
210
200
190
180
170
160
150
140
130
120
110
100
90
80
70
60
50
Alert
Verbal
Pain
Unresp
NEWS SCORE
BM
Pain
Nausea
U/O
Obs due
Initials

NHS GGC Hospitals, Emergency Department

(15)

NHS Greater Glasgow and Clyde

Affix Label

CHI: 1203893450

Royal Alexandra Hospital

Total Att: **54**

12 Mth Att: **15**

Title: **MR**

WEIR **James**

DOB: **12/03/1989** Age: **25y** Sex: **Male**

69a Fitzalan Court
Paisley
Renfrewshire
PA3 4UE
01418480859

Next of kin: **GUTHERIE, Mary**
Relationship: **Mother**
01418480859

GP: **DA Foster**
01475 501246

Attendance Date: **01/07/2014** Arrival Time: **23:15**

Registration Time: **23:15** Date of Incident: **01/07/2014**

Major Incident Desc:

Reason for Attendance: **found in close/exam**

Affix Label

Nursing Assessment

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

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

Presenting Complaint:

Observation Date: **02/07/2014 00:22** Nurse name: **Nurse Suzanne Gray**

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

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

Visual Acuity	
Left	
Right	
Corrected?	

GCS	
Eyes	
Motor	
Verbal	
Total	

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

Nursing Notes: **suicidal ideation**. Recent discharge Residential rehabilitation
Tearful in triage. Poor compliance re: medication.

97607

Child Assessment Questionnaire

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

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

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

DO NOT WRITE HERE PLEASE

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

Date	CLINICAL NOTES

Discharge Codes (Please CIRCLE)					Discharge date	
1. Admission	2. Discharge	3. Refer to GP	4. Transfer to other (see below)			
5. Died	6. Refer to OP Clinic (see below)		7. Irregular Discharge	8. D.O.A.	Discharge time	

Ward number (if admitted):	Transfer to hospital:	Consultant If admitted):

Follow up	Arranged			Not arranged			To be arranged	
Clinic referred to	A&E	Hand injury	Fracture	Pop Check	Medical	Surgical	ENT	Others (specify):

Discharge Prescription Packs

Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Frequency	Signature	Given By

Designed by Medical Illustration Services ref 243836

Date	2/7/14	CLINICAL NOTES
	Seen by (Dr) J. MCORMICK (LATIATE	Time seen 0210.

NEWS – National Early Warning Score

NHS
Greater Glasgow and Clyde

Name
Address



CHI No.
DoB

	Date	Ward
Admitted		
Transferred		
Transferred		

Physiological Parameter	NEWS – NHS Early Warning Score						
	3	2	1	0	1	2	3
Respiration Rate	≤8		9-11	12-20		21-24	≥25
Oxygen Saturations	≤91	92-93	94-95	≥96			
Any Supplemental Oxygen		Yes		No			
Temperature	≤35.0°		35.1-36.0°	36.1-38.0°	38.1-39°	≥39.1°	
Pulse	≤40		41-50	51-90	91-110	111-130	≥131
Systolic BP	≤90	91-100	101-110	111-219			≥220
Conscious Level				A			V, P or U

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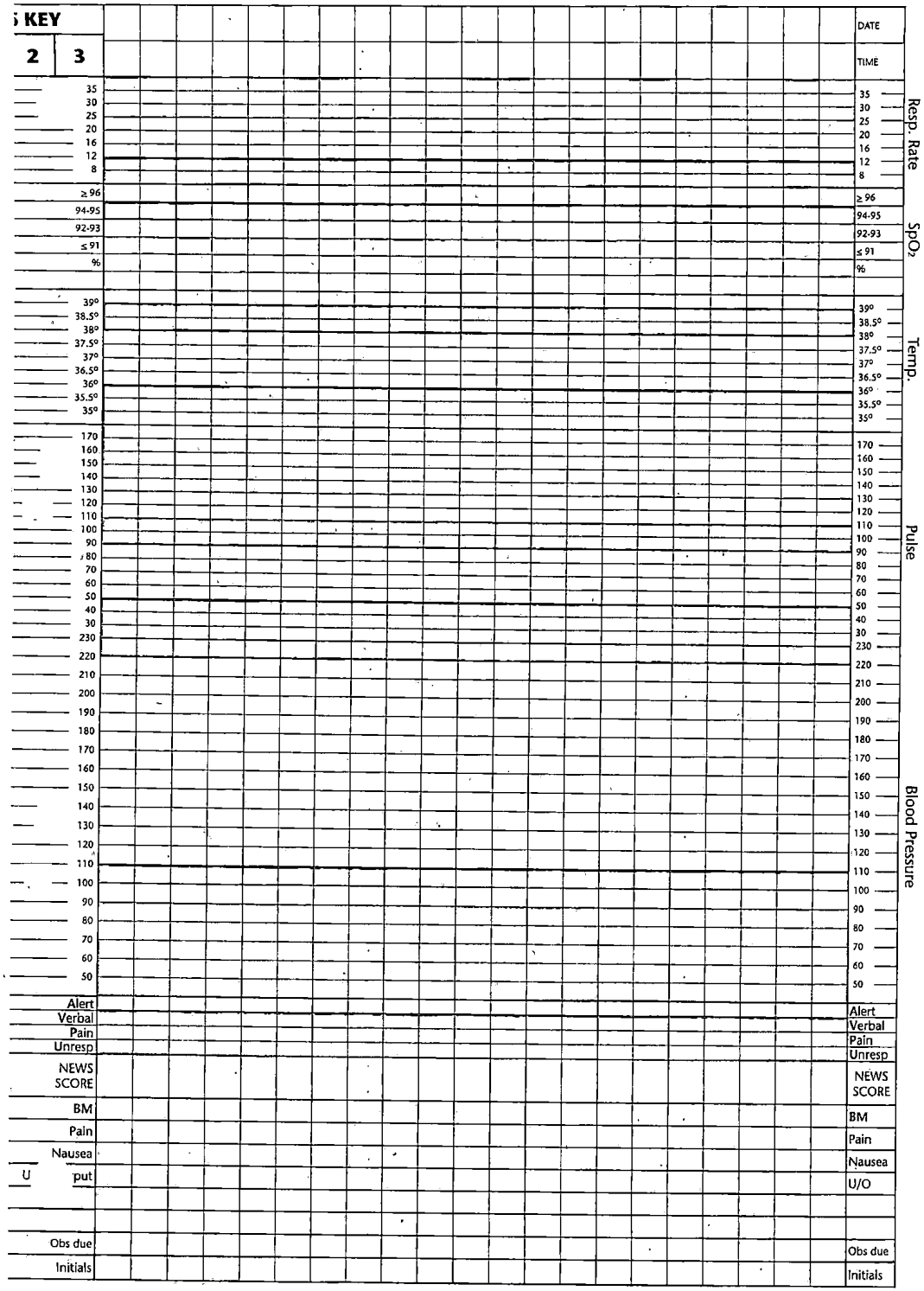
See NEWS Actions Reference Tool for local escalation policy

NEWS Score	Frequency of Monitoring	Clinical Response
0	Minimum 12 hourly	• Continue routine NEWS monitoring with every set of observations.
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Aggregate 5 or more or 3 in one parameter	Increased frequency to a minimum of 1 hourly	• Trained Nurse assessment. • Inform medical team caring for the patient. • Urgent assessment by a medical / surgical / nursing team with core competencies to assess acutely ill patients. • Consider level of monitoring required in relation to clinical care.
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| | | |

Neurological Observations

| | | |


KEY
2
3
DATE
TIME
Resp. Rate
35
30
25
20
16
12
8
SpO2
≥ 96
94-95
92-93
≤ 91
%
Temp.
39°
38.5°
38°
37.5°
37°
36.5°
36°
35.5°
35°
Pulse
170
160
150
140
130
120
110
100
90
80
70
60
50
40
30
230
220
210
200
190
180
170
160
150
140
130
120
110
100
90
80
70
60
50
Blood Pressure
Alert
Verbal
Pain
Unresp
NEWS SCORE
BM
Pain
Nausea
U/O
Obs due
Initials

Glasgow Emergency Departments
Mental Health Triage and Risk Assessment

this side to be completed by triage nurse

name 1203893450 12/03/1989
DoB WEIR James
CHI

1. Triage observations

GCS	BM	HR	BP	RR	SaO^2	Temp
15/15		86	120/71	13	97%	

accompanied by:

Blue Jeans. Blue/White Striped T Shirt. Grey Trainers Brown Hair. Approx 5'7" Slim build.

Unaccompanied

briefly describe patients attending alone (they may leave before assessment)

2. Outline of presentation

overdose – will require medical assessment		Suicidal Ideation states if discharged from ED will kill himself.
self-injury – will require wound management		
other mental health presentation	✓	

3. Inital presentation, appearance and behaviour

respond yes or no to each question

Is the patient violent, aggressive or threatening?	Yes		(No)
Is the patient obviously distressed, markedly anxious or highly aroused?		(Yes)	No
Is the patient quiet and withdrawn?		Yes	(No)
Do you think the patient is behaving inappropriately to their situation?		Yes	(No)
Do you think the patient presents an immediate risk to you, to others, or to themselves?	(Yes)		No
Do you think the patient is likely to abscond prior to assessment?	Yes		(No)
Do you think the patient's presentation suggests either delusions or hallucinations?*	Yes		(No)
Do you think the patient's presentation suggests they feel their actions are being controlled?.	Yes		(No)
Are you aware of a history of violence or self harm?		(Yes)	No
Are you aware of a history of mental health problems or psychiatric illness?		(Yes)	No

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

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

other patients can be categorized as **Moderate Risk**

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

4. Triage Risk Assessment

indicate risk category of patient in respect of risk of harm

(High) / Moderate / Low risk

of self-harm/~~violence/absconding~~ in department

Triage Category	2	high risk – supervised *and* in the department moderate risk – supervised *or* in the department low risk – can be asked to wait if necessary

5. Immediate management

Patient location, supervised by…	Bay 15.		
blood sample time?		toxbase information printed?	

print name EMMA JOHNSTON

signature

date 2/7/14 time 0025

Emergency Department Mental Health Assessment

this side to be completed by medical staff

outline of current presentation and precipitating factors

25 ♂.
Found in close tonight. Intoxicated. Been drinking buckfast and smoking heroin.
States feels suicidal. Wants to end his life tonight.
States has a stanley knife at home and knows he will go home + do it. States was in rehab → left on thursday drinking alcohol since. Mum unwell with cancer at minute. States cannot cope with life.

previous mental health problems, self harm, addictions, medication etc

Personal issues from years ago - unwilling to talk about.
→ Prev history self harm. - cutting wrists.
States was admitted to Psych hospital in Livingston + feels it helped.

other relevant information; relationships, finances, employment, housing, physical health, childcare etc

Lives alone.
Unemployed.
Poor relationship w/ sister.

Appearance	Behaviour	Speech
Jeans, Stripey top Trainers.	Appropriate	Normal Rate rhythm Volume
Mood	**Thought**	**Insight**
Low.	Suicidal intent ± formal thought disorder	Yes.

Is the patient a carer for a child or dependent adult? Y/N
Is there a child protection concern? Y/N

Risk assessment

based on clinical assessment indicate the category of risk of further episode of self harm / the risk of harm to others

consider both any protective and precipitating factors

High / Moderate / Low

negative responses in the 4 categories highlighted may allow patients to be categorised as low risk

Suicide Risk Factor	Yes	No	Unknown
male gender	y	n	u
age <18 or >65	y	n	u
depression	y	n	u
alcohol or drug use	y	n	u
separated, widowed, divorced	y	n	u
suicide plan/concealment	y	n	u
evidence of psychosis	y	n	u
ongoing suicial intent	y	n	u
lack of social support	y	n	u
chronic physical illness/pain	y	n	u
family history of suicide	y	n	u
family concern about risk	y	n	u
disengaged/poor compliance	y	n	u
unemployed or retired	y	n	u
access to lethal means of harm	y	n	u
previous violent methods	y	n	u
[illegible]	y	n	u
[illegible]	y	n	u
current psychiatric treatment	y	n	u
current use of benzodiazepines	y	n	u

Summary and plan for further assessment

Summary Ongoing suicidal ideation.

Service referred to IHTT. **time of referral** 02 15.

for patients awaiting assessment, indicate where they should wait, and who will supervise them; for patients to be transferred, indicate means of travel and anyone who will accompany them; for other outcomes, indicate the follow-up plan and name and relationship of the carers informed of this plan.

print name J. McCORMICK

signature

date 2/7/14 time 02[illegible]

3. MENTAL STATE ASSESSMENT :

Will include; Appearance/ behaviour. Mood, suicidal ideation. Psychotic symptoms. Cognitive functioning. Thought process and insight
May Include; Sleep, appetite. Relevant substance abuse. Relevant personal history.

Was found in alley tonight. Intoxicated. Been drinking buckfast and smoking heroin.

On assessment states he works locally in Rhyl, left on Thursday and has been drinking since. No recollection of events tonight. States he is struggling to cope due to past issues, claims to have been abused. Also mum has cancer.

Admits drinking 2 x bottles of buckfast daily, also smoking heroin and cannabis as well as taking ketamine. Claims to have not slept since Thurs. No ongoing suicidal intent. Plans to attend CAT to request readmission to rehab. Also going to contact team Challenge in Wales. Plans to see girlfriend later today.

Social circumstances: Lives alone, unhappy with accomodation. currently staying in homeless accomodation. Unemployed. Poor relationship.

Alcohol/Drug Hx

Excess alcohol/drug use since the age 13.

MSE/ Casually dressed. Cooperated with interview. Speech - normal. Mood - reactive. No ongoing suicidal intent or thoughts of self harm. No perceptual dysfunction. No formal thought disorder. Orientated. Reports poor sleep. ~~Appears to have limited insight into his drug and alcohol use and its impact on his~~ ?

Risk / History of DSH. No ongoing suicidal ideation or thoughts of self harm.
Impulsivity while under the influence.

E-Pacer PATIENT REPORT

Time 22:03 Date 01/07/2014

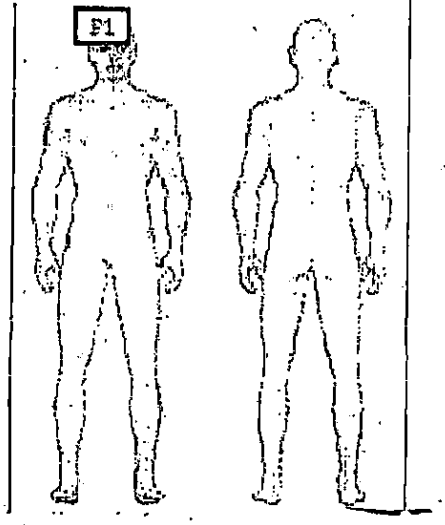
PATIENT AND INCIDENT DETAILS

Incident number	CR000416686.001
Name	WEIR JAMES
Address	FITZALLEN COURT, PAISLEY.
Age	25 year(s)
Date of birth	12/03/1989
Gender	Male
Incident location	(2) IN CLOSE TOWNHEAD TERRACE PAISLEY
Incident post code	PA1 2AX
Incident type	EMG
Call received	01/07/2014, 21:36
Call passed	01/07/2014, 21:35
Crew mobile	01/07/2014, 21:35
Crew at scene	01/07/2014, 21:38
Crew left scene	01/07/2014, 21:58
Patient at hospital	01/07/2014, 22:03
Receiving hospital and department	RAHP Royal Alexandra - Paisley

PRIMARY SURVEY

RESPONSE	
AVPU	Alert
AIRWAY	
Airway assessment	Clear
BREATHING	
Breathing rate	Normal
Respiratory rate	
CIRCULATION	
Pulse rate	Fast
Most peripheral pulse found	Radial
Cap refill rate	
Skin colour	Normal
Skin texture	Dry
C-SPINE INJURY	
Suspicion of CSI	No evidence of C-spine injury
PATIENT CONSENT	
Patient consent	Treatment benefits explained, Risks of condition explained, Risk of refusal explained, Capacity to understand risks and treatment, Advice given to patient

INJURIES



AMPDS

Dispatch code	31D02
Final code	26O01

Unconscious with Effective Breathing
Sick Person, No priority symptoms - 1st/2nd party

Out-of-Hours Crisis Service

NURSING ASSESSMENT

PIMS NO. ☐☐☐☐☐☐☐

PATIENT DETAILS

DATE .....

NAME James Weir

ADDRESS .....

1203893450 12/03/1989

**WEIR

James

.....

POSTCODE .....

DOB .....

TEL NO .....

GP .....

GP ADDRESS .....

.....

.....

.....

KNOWN TO SERVICE: YES ☐ NO ☐

IF SO, CONSULTANT/KEYWORKER

.....

TIME TRIAGED (24HR) HR ☐☐ MIN ☐☐

REFERRER: Dr McCormick.

ASSESSOR: Helen Walker / Liz Carr

TIME: VISITED HR ☐☐ MIN ☐☐

TIME: ASSESSMENT/CONTACT COMPLETE: (24HR) HR 03 MIN 00

VENUE PATIENT SEEN: HOME ☐ A&E ☐ HOSPITAL ☒

GEMS CLINIC ☐ POLICE ☐ OTHER ☐ (please specify) .....

HISTORY

1. REASON FOR REFERRAL/ HISTORY OF PRESENT CRISIS :

Ongoing suicidal ideation

2. RELEVANT PSYCHIATRIC/ MEDICAL HISTORY/ PRESENT MEDICATION:

History of addiction problems

Not currently open to services.

GCS

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

VITAL SIGNS

Time hr : min	Pulse bpm	Pulse rhythm	Resp. rpm	BP mm Hg	Cap refill (secs)	Peak flow %	Blood sugar mmol / l	Pain score	Temp °C	SpO2 %	GCS Total	NEWS	RTS	ECG	Sepsis
21:43	107	Reg	16	115 / 80	<2 secs	-	6.2	0/10	36.6	98	15	1	7.6	Sinus tachy	1
21:55	105	Reg	14	115 / 80	<2 secs	-	6.2	1/10	36.6	99	15	1	7.6	Sinus tachy	1
:	-	-	-	- / -	-	-	-	-	-	-	-	-	-	-	0

SEPSIS

Sepsis: Pneumonia
Sepsis: UTI
Sepsis: Other infection
Sepsis: Abdo pain
Sepsis: Diarrhoea
Sepsis: Abdo distension
Sepsis: Meningitis
Sepsis: Cellulitis
Sepsis: Septic arthritis
Sepsis: Wound infection
Sepsis: Infected indwelling device

EYES AND PUPIL SIZE AND REACTION

	Left	Right
Pupil size	Normal	Normal
Pupil reaction	Normal	Normal

AMPLE

Allergies	
Other allergies	PENICILLIN
Medication	NIL
Past history	PSYCHIATRIC HX/SELF HARM.
Last eaten	2 hrs
Events prior	HAS BEEN DRINKING,FOUND LYING IN COMMON CLOSE.

EMERGENCY SERVICES ON SCENE

Paramedic	Technician
Police	

SUBSTANCES AFFECTING CONDITION

Alcohol

PATIENT HANDOVER

On arrival at scene	Lying
Scene removal	Walking
Transportation	Seated
Care delivery at hospital	Chair
Time of handover	22:05

FINAL OBSERVATION AND COMMENTS

999 CALL TO MALE REPORTED TO BE LYING IN A CLOSE UNCONS, O/A COMMUNITY WARDENS ON SCENE, PT LYING IN CLOSE, O/E PT INTOXICATED, WAS SLEEPING IN THE CLOSE, C/O SORE HEAD, FEELING SUICIDAL,RELUCTANT TO ATTEND A/E.

Report ID	26349974-6784-4433-b3b4-05a0ce8ee92f

SUMMARY

35yr old gentleman with a history of addiction problems.

On assessment no evidence of any suicidal ideation, has clear plans for future. Main primary problem remains Addiction

DIAGNOSIS: **ICD10 CODE:** F1.

FOLLOW UP

1.	**Client to seek follow up via GP**	☐
2.	**Client to contact Care Team**	☑
3.	**CPN will contact Care Team**	☐
4.	**Psychiatric Medical opinion requested**	☐
5.	**Admitted to Hospital**	☐
6.	**Urgent CMHT next day follow up**	☐

Plan / Agreed to contact local CAT.

APPROPRIATE REFERRAL: **YES** ☑ **NO** ☐

(If No, explain)

SIGNATURE [signature] CPN

NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

Affix Label

CHI: 1203893450

Royal Alexandra Hospital

Total Att: **53**

12 Mth Att: **14**

Title: **MR**

WEIR **James**

DOB: **12/03/1989** Age: **25y** Sex: **Male**

THE HAVEN
HORSECRAIGS
Kilmacolm
Renfrewshire
PA13 4TH
01418480859

Next of kin: **GUTHERIE, Mary**
Relationship: **Mother**
01418480859

GP: **DA Foster**
01475 501246

Attendance Date: **27/06/2014** Arrival Time: **22:58**

Registration Time: **22:58** Date of Incident: **27/06/2014**

Major Incident Desc:

Reason for Attendance: **suicidal**

Affix Label

Nursing Assessment

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

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

Presenting Complaint:

Observation Date: **27/06/2014 23:10** Nurse name: **Nurse Michelle Mccord**

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

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

Visual Acuity	
Left	
Right	
Corrected?	

GCS	
Eyes	
Motor	
Verbal	
Total	

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

Nursing Notes: **drinking buckfast tonight recently left the army (march) ? ptsd similar presentation earlier in the week**

Claims to have cut his torso with? what but won't show wounds.

97607

Child Assessment Questionnaire 1203893450 12/03/1989

WEIR
James

REPORT

Time 22 27/06/2014

	YES	NO
Previous attendanc		
History variable bet		
Examination not cc		
Delay in presentati		
Fracture/head injur		

ed

X-Ray and O being admitted)

PATIENT AND INCIDENT DETAILS

Incident number	CR000407692.001
Name	JAMES WEIR
Age	24 year(s)
Date of birth	12/03/1989
Gender	Male
Incident location	69A DUNDONALD ROAD PAISLEY
Incident post code	PA3 4NB
Incident type	EMG
Call received	27/06/2014, 22:19
Call passed	27/06/2014, 22:19
Crew mobile	27/06/2014, 22:20
Crew at scene	27/06/2014, 22:26

PRIMARY SURVEY

RESPONSE

AVPU	Alert

AIRWAY

Airway assessment	Clear

BREATHING

Breathing rate	Normal
Respiratory rate	20

CIRCULATION

Pulse rate	Normal
Most peripheral pulse found	Radial
Cap refill rate	<2 secs
Skin colour	Normal
Skin texture	Dry

PATIENT CONSENT

Patient consent	Treatment benefits explained, Capacity to understand risks and treatment, Advice given to patient

AMPDS

Dispatch code	26D01	Sick Person - Not Alert
Final code	25B03	Psychiatric, Threatening suicide

GCS

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

VITAL SIGNS

Time hr : min	Pulse bpm	Pulse rhythm	Resp. rpm	BP mm Hg	Cap refill (secs)	Peak flow %	Blood sugar mmol / l	Pain score	Temp °C	SpO2 %	GCS Total	NEWS	RTS	ECG	Sepsis
22:26	92	Reg	20	114 / 67	<2 secs	-	6.3	-	36.5	97	15	1	7.6	-	1

SEPSIS

Sepsis: Pneumonia
Sepsis: UTI
Sepsis: Other infection
Sepsis: Abdo pain
Sepsis: Diarrhoea
Sepsis: Abdo distension
Sepsis: Meningitis
Sepsis: Cellulitis
Sepsis: Septic arthritis
Sepsis: Wound infection
Sepsis: Infected indwelling device

Date Given	[				n	Signature	Given By

Date	CLINICAL NOTES
27/06/14 Cont	pt advised he needs to tell me more info so I can help him. He stated he was annoyed that we wouldn't help him but declined to tell me any more info. SH- lives alone - Smokes 1 pack/day - Polydrug use - Alcoholism Δ- Identified presents to press Plan- discuss w/ Dr Bell → DH- NKDA - States nil new → home c GP follow up - Pt encouraged to enquire c GP follow up.

Discharge Codes (Please CIRCLE)								Discharge date	
1. Admission	2. Discharge	3. Refer to GP	4. Transfer to other (see below)						
5. Died	6. Refer to OP Clinic (see below)		7. Irregular Discharge		8. D.O.A.			Discharge time	

Ward number (if admitted):	Transfer to hospital:	Consultant If admitted):

Follow up	Arranged			Not arranged			To be arranged	
Clinic referred to	A&E	Hand injury	Fracture	Pop Check	Medical	Surgical	ENT	Others (specify):

Discharge Prescription Packs

Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Frequency	Signature	Given By

Date	27/06/14	CLINICAL NOTES
	Seen by (Dr) Dawn (pt in police custody)	Time seen 2340

(25)♂ Reattending c identical presentation to last night. Pt very cautious c information sharing. little Hx from pt.

Pt contacted NHS24 after taking cannabis, smoking heroin + drinking alcohol +++.

Pt stating a man "Alex Walker" sexually abused him over a period of years. This man has been released on bail.

James states he wants to kill him but not actually aware of how he would go about this.

Pt claims to have cut himself c a stanley knife but refuses to either show me this or tell me where he did this.

Pt states he is suicidal but again no plans for how he would do this and had an identical presentation last night.

Often plans are made to have him followed up by GP.

ograph Label

Nursing Notes

Date and Time		Print Name and Signature

Emergency Department - Active Care

I have evaluated and deemed that the frequency of care delivery over the next work shift, based on the patient's most critical need should be every:

(Please circle) ½ hour 1hour 2 hours

Signed ..... Name .....

Patient Addressograph Label

			Time							
	1.	PAIN: Assess and address If in pain inform registered nurse Y or N/A								
S	2.	SKIN INSPECTION A. Pressure areas checked:								
		B. Redness (R) / Discolouration (D) / Pressure Ulcer (PU)								
K	3.	KEEP MOVING: A. Have you moved or walked Y / N / I (independent)								
		B. Trolley Right side (30° tilt) – R Left Side (30° tilt) – L Back– B								
		C. Chair Assist to walk, stand or tilt (W /ST/ T)								
I	4.	ELIMINATION: Do you need the toilet? I = Independent A = Assistance given IC = patient incontinent of urine/faeces								
N	5.	FOOD, FLUIDS AND NUTRITION: Is the patient nil by mouth? Y / N (consider mouth care)								
		Encourage the patient to drink? (if appropriate) Y / N / N/A								
		Food, snack or supplement taken? (if appropriate) Y / N / N/A								
	6.	ENVIRONMENT: Is the patient able to call for assistance? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the trolley in lowest position?								
	7.	INFORMATION: Ask: Is there anything else I can help you with? Inform patient of the time of return.								
	8.	ESCALATION: Escalate any issues to the Registered Nurse / Dr Y / N/A								
		Nurse Initials								

USE FOLLOWING CODE	Specialist Pressure Redistributing equipment	Variations			
V = Variant I = Independent NT = No thanks	☐ Repose Mattress ☐ Moving and handling aids ☐ Other:	Time	No.	Variation	Signed

Waterlow Pressure Area Risk Assessment

Build/Weight		Skin Type/Visual Risk Areas		Sex/Age		Special Risks - Tissue Malnutrition	
Average (BMI 20-24.9)	0	Healthy	0	Male	1	Multiple organ failure/ Terminal cachexia	8
Above Average (BMI 25-29.9)	1	Tissue Paper (thin/fragile)	1	Female	2		
Obese (BMI > 30)	2	Dry (appears flaky)	1	14-49	1	Single organ failure	5
Below Average (BMI < 20)	3	Oedematous (puffy)	1	50-64	2	Peripheral Vascular Disease	5
Continence		Clammy /pyrexia	1	65-74	3	Anaemia = Hb < 8	2
Complete/Catheterised	0	Discoloured (bruising/mottled)	2	75-80	4	Smoking	1
Incontinent urine	1			81+	5	Neurological Deficit	
Incontinent faeces	2	Broken (established ulcer)	3	Nutritional Element		Diabetes/MS/CVA Motor or sensory paraplegia (Max 6)	4-6
Doubly Incontinent (urine and faeces)	3	Mobility		Unplanned weight loss in past 3-6 months < 5% Score 0 5-10% Score 1 > 10% Score 2			
		Fully mobile	0				
Special Risks – Surgery/Trauma		Restless/Fidgety	1			Special Risks - Medication	
On table > 6 hours	8	Apathetic (sedated/depressed/ reluctant to move)	2			Cytotoxic, anti-inflammatory, long term/high dose steroids (Max 4)	4
Orthopaedic / below waist/Spinal (up to 48 hrs post-op)	5			BMI > 20 Score 0 BMI 18.5-20 Score 1 BMI < 18.5 Score 2		Risk Score 10+ = 'At risk' 15+ = 'High Risk' 20+ = 'Very High Risk'	
On table > 2 hours (up to 48 hrs post op)	5	Bed bound (unconscious/unable to change position/traction)	4				
		Chair Bound	5	Patient acutely ill or no nutritional intake > 5 days	2		

Patient's Initial Waterlow Score = If Score ≥10 Complete the Adapted Waterlow Pressure Area Risk Assessment Chart.

Patient Addressograph Label

Pause for Discharge (Please tick when completed)	Tick when completed	N/A	Notes
Advice leaflets given	☐	☐	Information on discussion with relatives
Belongings (including patient's medications)	☐	Always	
New medications explained	☐	☐	
Cannula removed	☐	☐	
Relatives aware of discharge	☐	☐	Please note here if any other tasks required prior to discharge
Social/ Support Services required and contacted	☐	☐	
SAS transport required and ref no	☐	☐	Print name
Other means of transport arranged by nurse	☐	☐	

Nursing Notes

Date and Time		Print Name and Signature
2330	PT IN ROOM SITTING ON CHAIR WITH X2	
	POLICE CONSTABLES PRESENT. S/B ATE SHO	

Emergency Department Nursing Documentation

NHS Greater Glasgow and Clyde

Patient Addressograph Label

JAMES WEIR
1203893450

Presenting Complaint: SOLICITOR

Date and Time: 27/6/14 23-30

Named Nurse(s):

Patient preparation (Please tick when completed)	Initials:	
Prepare patient for examination	N/A	☐
Provide blankets if required	N/A	☐
Clothing bagged, labelled and stored under trolley	N/A	☐
Name-band (if required)		☐

Communication (Please tick when completed)	Initials:	
Communication Aids (spectacles / hearing aid)		☐
~~Relatives~~ present?	POLICE	☑
Relatives / NOK informed		☐
Interpreter required		☐
Telephone interpretation required		☐

Observations and Investigations (Please tick when completed)		Initials:	
Vital Signs recorded on NEWS chart and NEWS score recorded. Record Pain, blood sugar and neuro obs on NEWS chart if appropriate.			☐
Peak Flow 1. 2. 3.			☐
12 Lead ECG			☐
Cardiac Monitoring			☐
X-rays performed			☐
Other: please add			☐
IV Cannula (if required) dated and timed			☐
Blood samples taken			☐
Urinalysis and Specimen if indicated *Results:*			☐
HCG specimen if indicated +ve ☐ -ve ☐ Strip Lot no:			☐
Weight:			☐

Screening Tools (Please circle or tick as appropriate)		Initials:	
SEPSIS risk? SIRS Criteria 2 or more and suspicion of infection	Y / N	**Preliminary Pressure Ulcer Risk Assessment** The patient can reposition themselves whilst in the department?	Y / N
AMT 4 (if >65 years) SCORE	/4	There is no reported skin damaged other than presenting trauma?	Y / N
At risk of falls? (clinical judgement) (consider alcohol, mobility, age, illness, cognitive impairment etc). *If at risk complete risk assessment*	Y / N	The person is fully continent? *If NO to any of the above initiate Waterlow risk assessment (within 4 hrs)*	Y / N
Mental Health Triage Assessment	Y / N	**Waterlow Score** *If >10 commence Active Care*	☐
Child Protection considered (in line with policy)	Y / N	**Active Care** (clinical judgement) (include all trolley patients at risk of pressure ulcers and all trolley patients in department for >4hrs) *Record on Active Care Chart*	☐
GMAWS	Y / N	Pressure damage identified on arrival in ED is documented in clinical notes	☐
Swallow test (If CVA/stroke)	Y / N	Grade 3 or 4 Pressure Ulcers are reported on DATIX	☐

Pause for Transfer (Please tick when completed)		Tick when completed	N/A	**Notes**
	Relatives informed	☐	☐	Information on discussion with relatives
	Cannula dated and timed	☐	☐	
	Name band	☐	☐	
	AMT4	☐	☐	
	NEWS chart	☐	Always	
Prescriptions signed	Infusions	☐	☐	
	Drugs	☐	☐	
	Fluids	☐	☐	
	GMAWS	☐	☐	
	Belongings (including patient's medications)	☐	Always	Please note here if any other tasks required prior to transfer
	Bed requested, accepted and ward informed	☐	Always	
	Notes: medical notes, GP letter, PRF	☐	Always	
Investigations	CXR reviewed	☐	☐	
	ECG reviewed	☐	☐	Print name
	Bloods sent	☐	☐	
	Bloods reviewed	☐	☐	
	Patient on O_2: cylinder checked	☐	☐	
	Patients requiring analgesia: sufficient	☐	☐	

NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

Name
Address

1203893450 12/03/1989
WEIR
James

CHI No.
DoB

	Date	Ward
Admitted		
Transferred		
Transferred		

Physiological Parameter	NEWS – NHS Early Warning Score						
	3	2	1	0	1	2	3
Respiration Rate	≤8		9-11	12-20		21-24	≥25
Oxygen Saturations	≤91	92-93	94-95	≥96			
Any Supplemental Oxygen		Yes		No			
Temperature	≤35.0°		35.1-36.0°	36.1-38.0°	38.1-39°	≥39.1°	
Pulse	≤40		41-50	51-90	91-110	111-130	≥131
Systolic BP	≤90	91-100	101-110	111-219			≥220
Conscious Level				A			V, P or U

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

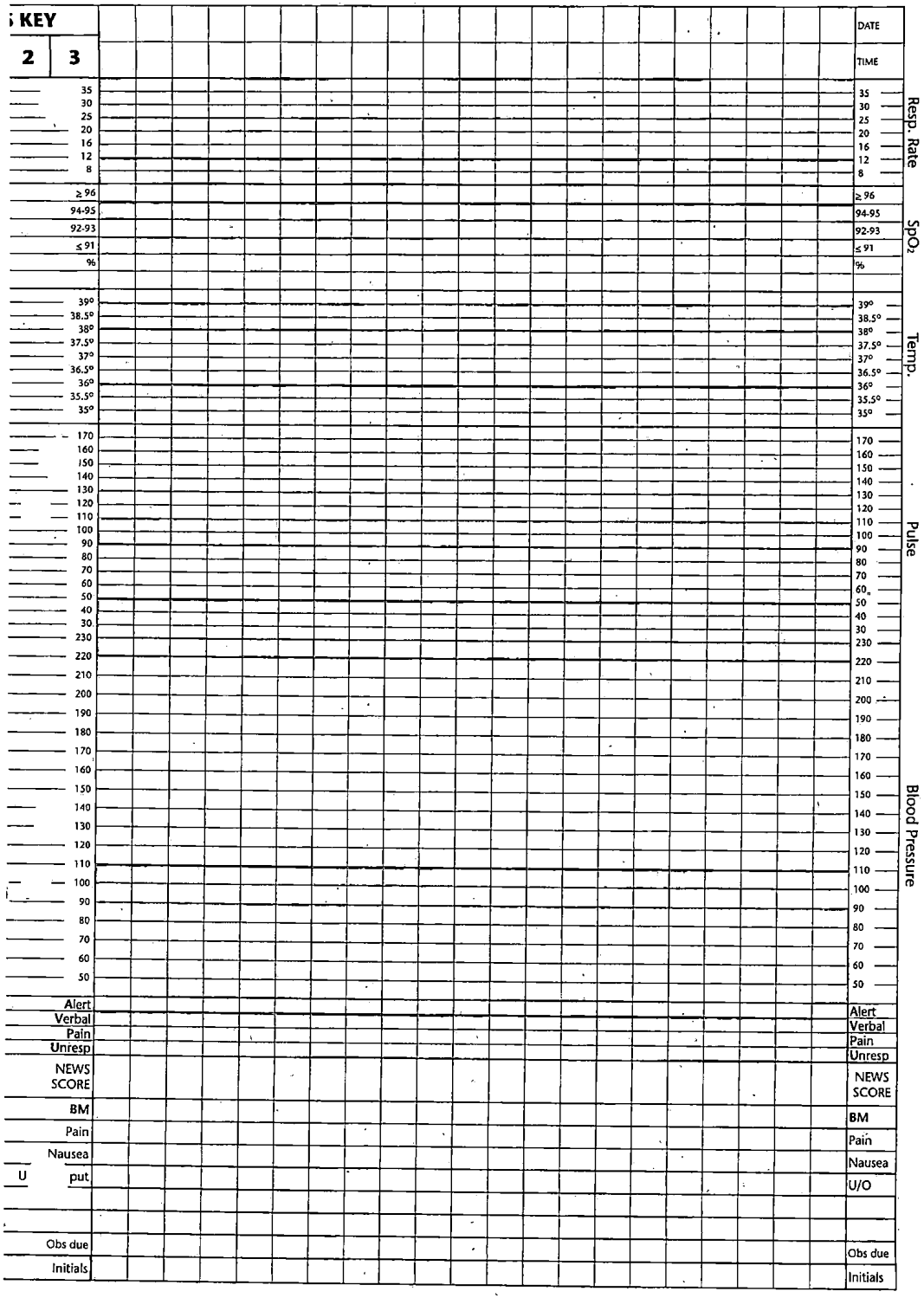
See NEWS Actions Reference Tool for local escalation policy

NEWS Score	Frequency of Monitoring	Clinical Response
0	Minimum 12 hourly	• Continue routine NEWS monitoring with every set of observations.
Aggregate 1- 4	Minimum 4 hourly	• Inform trained nurse. • Trained Nurse assessment: - Assess the patient - Review frequency of monitoring required - Assess need for escalation of clinical care and direct as appropriate.
Aggregate 5 or more or 3 in one parameter	Increased frequency to a minimum of 1 hourly	• Trained Nurse assessment. • Inform medical team caring for the patient. • Urgent assessment by a medical / surgical / nursing team with core competencies to assess acutely ill patients. • Consider level of monitoring required in relation to clinical care.
Aggregate 7 or more	Continuous monitoring of vital signs	• Trained Nurse to assess immediately. • Inform medical team caring for the patient – this should be at least senior medical staff level. • Emergency assessment by a clinical team with core competencies in the assessment of critically ill patients. This team will have critical care competencies and a practitioner/s with advanced airway skills and resuscitation skills. • Consider referral to high dependency or ITU.

| | | |

Neurological Observations

| | | |


KEY
2
3
DATE
TIME
Resp. Rate
35
30
25
20
16
12
8
SpO2
≥ 96
94-95
92-93
≤ 91
%
Temp.
39°
38.5°
38°
37.5°
37°
36.5°
36°
35.5°
35°
Pulse
170
160
150
140
130
120
110
100
90
80
70
60
50
40
30
Blood Pressure
230
220
210
200
190
180
170
160
150
140
130
120
110
100
90
80
70
60
50
Alert
Verbal
Pain
Unresp
NEWS SCORE
BM
Pain
Nausea
U/O
Obs due
Initials

Glasgow Emergency Departments
Mental Health Triage and Risk Assessment

this side to be completed by triage nurse

name
DoB 1203893450 12/03/1989
CHI WEIR James

1. Triage observations

document any physiological measurements

GCS	BM	HR	BP	RR	SaO^2	Temp
15/15						

accompanied by

name, relationship, particular concerns

Police.
Red Zipper Jacket
Jeans
Black/grey boots
Blue Polo T-shirt
approx 5'11
Slim build.

briefly describe patients attending alone (they may leave before assessment)

2. Outline of presentation

tick all those categories which apply and provide a brief summary

overdose – will require medical assessment		recently left army in March? PTSD.
self-injury – will require wound management		drinking Buckfast tonight. Similar episode
other mental health presentation	✓	earlier this week.

3. Initial presentation: appearance and behaviour

respond yes or no to each question

Is the patient violent, aggressive or threatening? says she feels very angry	(Yes)		No
Is the patient obviously distressed, markedly anxious or highly aroused?		Yes	No
Is the patient quiet and withdrawn?		(Yes)	No
Do you think the patient is behaving inappropriately to their situation?		Yes	(No)
Do you think the patient presents an immediate risk to you, to others, or to themselves?	(Yes)		No
Do you think the patient is likely to abscond prior to assessment?	(Yes)		No
Do you think the patient's presentation suggests either delusions or hallucinations?*	Yes		(No)
Do you think the patient's presentation suggests they feel their actions are being controlled?	Yes		(No)
Are you aware of a history of violence or self harm?		(Yes)	No
Are you aware of a history of mental health problems or psychiatric illness?		(Yes)	No

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

any responses in the first column
High Risk

other patients can be categorized as
Moderate Risk

unless all responses are in the third column
Low Risk

4. Triage Risk Assessment

indicate triage category by ticking one and sub-categorise if appropriate

(High) / Moderate / Low risk

of self-harm/violence/absconding in department

Triage Category		
		high risk – supervised *and* in the department
		moderate risk – supervised *or* in the department
		low risk – can be asked to wait if necessary

5. Immediate management

with toxbase information and supervised/approved observations/touch-me to samples

Patient location, supervised by…	Police in CWA		
blood sample time?		toxbase information printed?	N/A

print name _____

signature _____

date _____ time _____

Emergency Department Mental Health Assessment

inside to be completed by medical staff

outline of current presentation and precipitating factors

previous mental health problems, self harm, addictions, medication etc

other relevant information; relationships, finances, employment, housing, physical health, childcare etc

Appearance	Behaviour	Speech
Mood	Thought	Insight

Is the patient a carer for a child or dependent adult? Y/N

Is there a child protection concern? Y/N

Risk assessment

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

High / Moderate / Low

negative responses in the 4 categories highlighted may allow patients to be categorised as low risk

Suicide Risk Factors (yes/no/unknown)			
male gender	y	n	u
age <18 or >65	y	n	u
depression	y	n	u
alcohol or drug use	y	n	u
separated, widowed, divorced	y	n	u
suicide plan/concealment	y	n	u
evidence of psychosis	y	n	u
ongoing suicial intent	y	n	u
lack of social support	y	n	u
chronic physical illness/pain	y	n	u
family history of suicide	y	n	u
family concern about risk	y	n	u
disengaged/poor compliance	y	n	u
unemployed or retired	y	n	u
access to lethal means of harm	y	n	u
previous violent methods	y	n	u
[illegible]	y	n	u
[illegible]	y	n	u
[illegible]	y	n	u
[illegible]	y	n	u

Summary and plan for further assessment

e.g. referral to liaison psychiatry duty doctor, CPN, voluntary MH service, addiction services etc

Summary

Service referred to	time of referral

for patients awaiting assessment, indicate where they should wait, and who will supervise them; for patients to be transferred, indicate means of travel and anyone who will accompany them; for other outcomes, indicate the follow-up plan and name and relationship of the carers informed of this plan.

print name _____

signature _____

date _____ time _____

0104373326

NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

2

~~C E A~~

Affix Label

CHI: 1203893450

Royal Alexandra Hospital

Total Att: **52**

12 Mth Att: **13**

Title: **MR**

WEIR **James**

DOB: **12/03/1989** Age: **25y** Sex: **Male**

THE HAVEN
HORSECRAIGS
Kilmacolm
Renfrewshire
PA13 4TH
01418480859

Next of kin: **GUTHERIE, Mary**
Relationship: **Mother**
01418480859

GP: **DA Foster**
01475 501246

Attendance Date: **26/06/2014** Arrival Time: **20:35**

Registration Time: **20:35** Date of Incident: **26/06/2014**

Major Incident Desc:

Reason for Attendance: **mental health issue**

Nursing Assessment

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

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

Presenting Complaint:

Observation Date: **26/06/2014 20:37**

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

Nurse name: **Nurse Diana Clark**

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

GCS	
Eyes	
Motor	
Verbal	
Total	

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

Nursing Notes: **hx psychiatric problems, tonight very stressed about personal issue. behaiving strangely in triage, not verbalising.**

Child Assessment Questionnaire

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

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

X-Ray and Other Reports to be filed on this side (if the patient is not bei[illegible]dmitted)



DS GORDON MCCRAE K80-
0141 435 1006
POLICE SCOTLAND

DO NOT WRITE HERE PLEASE

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

Date	CLINICAL NOTES
	Imp: Suicidal. Strong active suicidal ideation. Feels socially isolated. Hopeless. Plan/ Refer psych (Referred 22 45). MACLEAN GPST
2310.	Psych has called and will kindly review.

Discharge Codes (Please CIRCLE)					Discharge date	
1. Admission	2. Discharge	3. Refer to GP	4. Transfer to other (see below)			
5. Died	6. Refer to OP Clinic (see below)		7. Irregular Discharge	8. D.O.A.	Discharge time	

Ward number (if admitted):	Transfer to hospital:	Consultant If admitted):

Follow up	Arranged			Not arranged			To be arranged	
Clinic referred to	A&E	Hand injury	Fracture	Pop Check	Medical	Surgical	ENT	Others (specify):

Discharge Prescription Packs

Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Frequency	Signature	Given By

Date	CLINICAL NOTES
	Seen by (Dr) MALCN · Time seen 10 · 15 ·
26/6/14.	(25) ↗ suicidal.

Very tearful and not keen to speak to me. Eventually agreed to tell me some information.

Feeling suicidal and confided in a previous work colleague today who took him to the police station - police advised attendance here.

States that he was sexually abused 3 years ago. Has found out today that the man who did this to him is out on bail and he is petrified that he will find him and hurt him. States that when he tries to sleep all he sees and hears is this man.

Not eating + not sleeping.

Had been in residential rehab (for drug and alcohol abuse) but left today so he was given a flat.

Has been drinking today.

Previously had been smoking heroin and using crack cocaine.

States no contact with family and no friends.

The lady he confided in today was a former colleague from when he used to volunteer at the food bank.

States he has previously used to self harm (cut himself) ~~x0~~). States he has seen a psychiatrist before.

Has been on venlaflaxine since she was a teenager.

No evidence of psych contact on portal.

Patient states that he is scared to go home as he is scared of what he will do to himself. Does not have any firm plan of what he will do but says he will do "whatever he can" to ensure he is no longer here.

Has been told he has to go to court and states he cannot face seeing the man who abused him again.

Not waking.

Fully orientated in T, P + P.

Out-of-Hours Psychiatric Nursing Service

NURSING ASSESSMENT

PATIENT DETAILS

Date

Name 1203893450

Address WEIR, James, M, 12/03/1989
THE HAVEN
HORSECRAIGS
Kilmacolm, Renfrewshire
PA13 4TH

Post Code

DOB

Tel No

PiMS No

GP Name Dr. DA Foster
Dr D A Foster & Dr A E Crawford

GP Address The Health Centre
20 Duncan Street
Greenock
PA15 4LY

Known to Service: YES ☐ NO ☐

If so, Consultant/Keyworker Name:

Time Triaged (24Hr)

HR	MIN

Referrer: RAH A+E

Assessor: E. CARR M M'CREADIE

Time Visited

HR	MIN
03	40

Time Assessment/Contact Completed

HR	MIN

Venue Patient See At:

Home ☐
GEMS Clinic ☐
Other ☐ (Please specify): RAH.

A&E ☑
Police ☐

Hospital ☐

HISTORY

1. Reason for Referral/History of Present Crisis:

Had been paranoid earlier that he was being watched and potentially at risk from a man he claims sexually assaulted him. 3 years ago. Feels depressed, withdrawn and isolated. Finished 6 week drug + alcohol rehab yesterday.

2. Relevant Psychiatric/Medical History/Present Medication:

Not currently known to psychiatric services.
No previous involvement w/ psychiatric services.
States he is not on any medication.

Summary

25 year old man discharged yesterday after 6 week rehab for drug + alcohole - immediately bought alcohol. Had to attend Police station and was advised alleged abuser is on bail - Now warned he will be targeted again.
No evidence of any psychotic & or any perceptual disturbance long Hx maladaptive coping - drinking, using drugs and self harming. - seeking admission as he does not like living alone. Offered referral to CAT for ongoing support, but declined this. Positive re plans he has for his future both in short and long term

Diagnosis:	ICD10 Code:	

Follow Up

1	Client to seek follow up via GP	☑
2	Client to contact Care Team	☐
3	CPN will contact Care Team	☐
4	Psychiatric medical opinion requested	☐
5	Admitted to hospital	☐
6	Urgent CMHT next day follow up	☐

1) Plans to return to police station on Tuesday as arranged.
Plans to arrange appt to have mare D'Arbe.
Plans to seek referral to Teen challenge in Leicester.
Declined referral to CAT.
Advised to attend GP if he wishes to reconsider.

Appropriate referral: Yes ☑ No ☐
(If No, explain):

Signature: M. McGrade (CPN)

3. Mental State Assessment:

Will Include: Appearance/Behaviour, mood, Suicidal Ideation, Psychotic symptoms, Cognitive functioning, Thought process and insight

May Include: Sleep, Appetite, Relevant substance abuse, Relevant personal history

Casually dressed man wearing jeans + red jacket.
Initially asleep and easily roused from sleep.
Eye contact was good - speech quiet tone normal rate and rhythm.
Behaviour throughout was good with no evidence of any aggression / violent behaviour.
Did not appear agitated or anxious.
Today had confided in an ex colleague that he was feeling suicidal and she took him to Police station.
Has been involved in court case where he alleges he has been ~~stalked~~ abused for a period of time until 1 year ago. He stated at today that his abuser is on bail and he is now afraid that he will be targeted again.
He has been in a drug rehab for past 6 weeks until today when he left there to go to his own tenancy.
He states that for 2 years he has been using heroin and alcohol on a daily basis. He states that he went straight to shops today when discharged from rehab and bought a bottle of Buckfast.
He states that he has been suicidal for a lengthy period of time and has taken numerous overdoses and cut himself many times in the past. - worries that he may harm self in future but no active plan or intent noted.
He reports that he has been able to hear a voice calling his name which comes from inside his head. He did not appear to be distracted or preoccupied during assessment and there was no evidence of any thought disorder.
He reports that his sleep is disturbed due to nightmares and also reports that he has lost 4 stones in weight over recent months.
He has a new flat now but claims this is in a bad area and he plans to have a meeting to arrange a move.
He appears to be flat in his affect and mood was lowered due to being at Police station.
Plans to attend Police station on Tuesday for ID parade.
Plans long term to go ~~Teen challenge~~ in Leicester for rehab.

NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

Name
Address

1203893450 12/03/1989
WEIR
James

CHI No.
DoB

	Date	Ward
Admitted	26/6/14	AFE
Transferred		
Transferred		

Physiological Parameter	NEWS – NHS Early Warning Score						
	3	2	1	0	1	2	3
Respiration Rate	≤8		9-11	12-20		21-24	≥25
Oxygen Saturations	≤91	92-93	94-95	≥96			
Any Supplemental Oxygen		Yes		No			
Temperature	≤35.0°		35.1-36.0°	36.1-38.0°	38.1-39°	≥39.1°	
Pulse	≤40		41-50	51-90	91-110	111-130	≥131
Systolic BP	≤90	91-100	101-110	111-219			≥220
Conscious Level				A			V, P or U

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

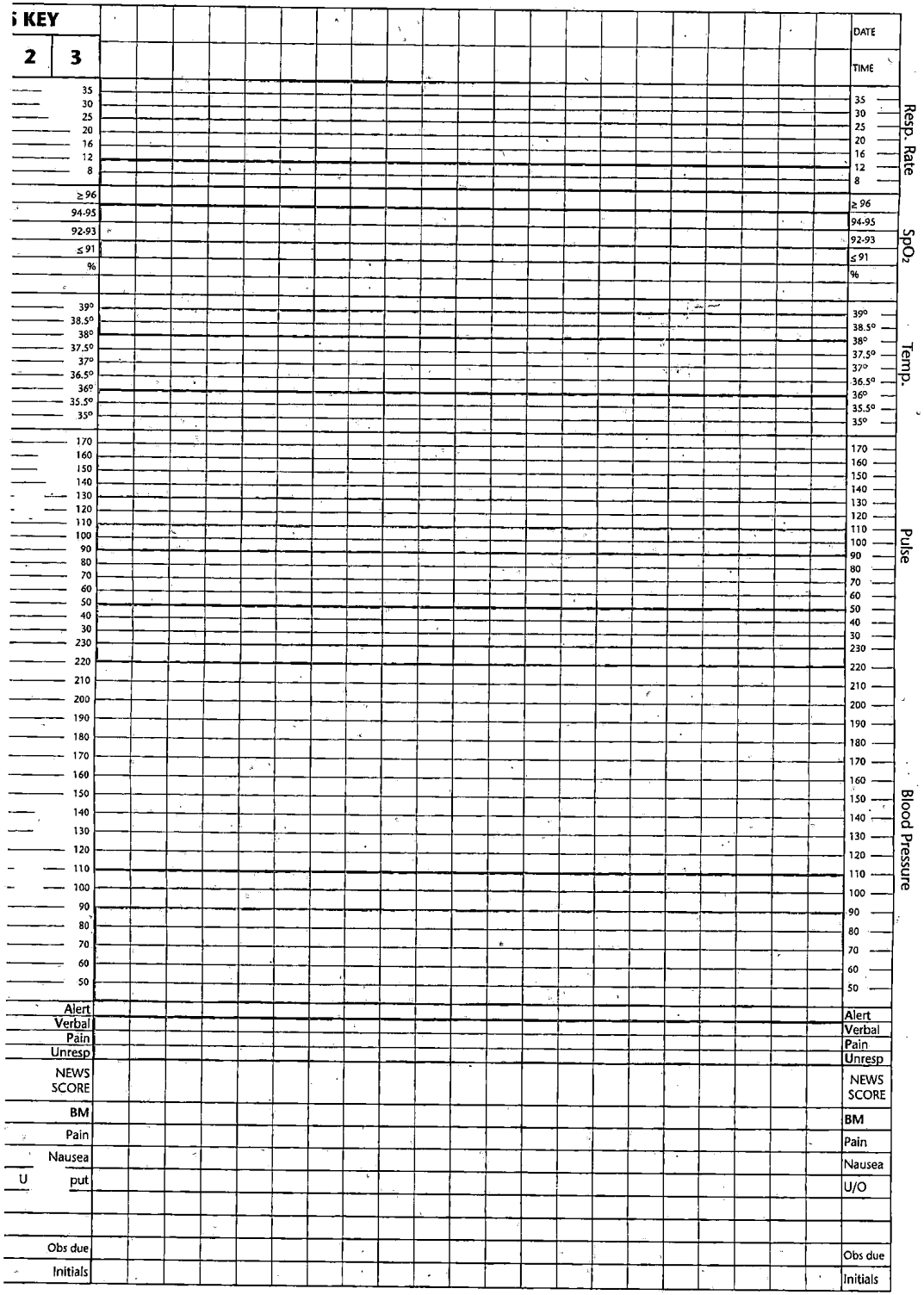
See NEWS Actions Reference Tool for local escalation policy

NEWS Score	Frequency of Monitoring	Clinical Response
0	Minimum 12 hourly	• Continue routine NEWS monitoring with every set of observations.
Aggregate 1- 4	Minimum 4 hourly	• Inform trained nurse. • Trained Nurse assessment: - Assess the patient - Review frequency of monitoring required - Assess need for escalation of clinical care and direct as appropriate.
Aggregate 5 or more or 3 in one parameter	Increased frequency to a minimum of 1 hourly.	• Trained Nurse assessment. • Inform medical team caring for the patient. • Urgent assessment by a medical / surgical / nursing team with core competencies to assess acutely ill patients. • Consider level of monitoring required in relation to clinical care.
Aggregate 7 or more	Continuous monitoring of vital signs	• Trained Nurse to assess immediately. • Inform medical team caring for the patient – this should be at least senior medical staff level. • Emergency assessment by a clinical team with core competencies in the assessment of critically ill patients. This team will have critical care competencies and a practitioner/s with advanced airway skills and resuscitation skills. • Consider referral to high dependency or ITU.

| | | |

Neurological Observations

| | | |


KEY
2
3
DATE
TIME
Resp. Rate
35
30
25
20
16
12
8
SpO2
≥ 96
94-95
92-93
≤ 91
%
Temp.
39°
38.5°
38°
37.5°
37°
36.5°
36°
35.5°
35°
Pulse
170
160
150
140
130
120
110
100
90
80
70
60
50
40
30
230
220
210
200
190
180
170
160
150
140
130
120
110
100
90
80
70
60
50
Blood Pressure
Alert
Verbal
Pain
Unresp
NEWS SCORE
BM
Pain
Nausea
U/O
put
Obs due
Initials

Emergency Department Nursing Documentation

NHS Greater Glasgow and Clyde

Patient Addressograph Label

1203893450 12/03/1989
WEIR
James

Presenting Complaint: ↓ vomiting.

Date and Time: 26/6/14 22:00 hrs.

Named Nurse(s): WALKER.

Patient preparation (Please tick when completed)	Initials:	Communication (Please tick when completed)	Initials:
Prepare patient for examination	☐	Communication Aids (spectacles / hearing aid)	☐
Provide blankets if required	☐	Relatives present? NO.	☐
Clothing bagged, labelled and stored under trolley	☐	Relatives / NOK informed	☐
Name-band (if required) Allergies nor known.	☐	Interpreter required	☐
		Telephone interpretation required	☐

Observations and Investigations (Please tick when completed)		Initials:	
Vital Signs recorded on NEWS chart and NEWS score recorded. Record Pain, blood sugar and neuro obs on NEWS chart if appropriate.	☐	IV Cannula (if required) dated and timed	☐
Peak Flow 1. 2. 3.	☐	Blood samples taken	☐
12 Lead ECG	☐	Urinalysis and Specimen if indicated *Results:*	☐
Cardiac Monitoring	☐		
X-rays performed	☐	HCG specimen if indicated +ve ☐ -ve ☐ Strip Lot no:	☐
Other: please add	☐	Weight:	☐

Screening Tools (Please circle or tick as appropriate)		Initials:	
SEPSIS risk? SIRS Criteria 2 or more and suspicion of infection	Y / N	**Preliminary Pressure Ulcer Risk Assessment** The patient can reposition themselves whilst in the department?	Y / N
AMT 4 (if >65 years) SCORE	/4	There is no reported skin damaged other than presenting trauma?	Y / N
At risk of falls? (clinical judgement) (consider alcohol, mobility, age, illness, cognitive impairment etc). *If at risk complete risk assessment*	Y / N	The person is fully continent? *If NO to any of the above initiate Waterlow risk assessment (within 4 hrs)*	Y / N
Mental Health Triage Assessment	(Y) / N	**Waterlow Score** *If >10 commence Active Care*	☐
Child Protection considered (in line with policy)	Y / N	**Active Care** (clinical judgement) (include all trolley patients at risk of pressure ulcers and all trolley patients in department for >4hrs) *Record on Active Care Chart*	☐
GMAWS	Y / N	Pressure damage identified on arrival in ED is documented in clinical notes	☐
Swallow test (If CVA/stroke)	Y / N	Grade 3 or 4 Pressure Ulcers are reported on DATIX	☐

Pause for Transfer (Please tick when completed)		Tick when completed	N/A	Notes
	Relatives informed	☐	☐	Information on discussion with relatives
	Cannula dated and timed	☐	☐	
	Name band	☐	☐	
	AMT4	☐	☐	
	NEWS chart	☐	Always	
Prescriptions signed	Infusions	☐	☐	
	Drugs	☐	☐	
	Fluids	☐	☐	
	GMAWS	☐	☐	
	Belongings (including patient's medications)	☐	Always	Please note here if any other tasks required prior to transfer
	Bed requested, accepted and ward informed	☐	Always	
	Notes: medical notes, GP letter, PRF	☐	Always	
Investigations	CXR reviewed	☐	☐	
	ECG reviewed	☐	☐	Print name
	Bloods sent	☐	☐	
	Bloods reviewed	☐	☐	
	Patient on O_2: cylinder checked	☐	☐	
	Patients requiring analgesia: sufficient	☐	☐	

Patient Addressograph Label

Pause for Discharge (Please tick when completed)	Tick when completed	N/A	Notes
Advice leaflets given	☐	☐	Information on discussion with relatives
Belongings (including patient's medications)	☐	Always	
New medications explained	☐	☐	
Cannula removed	☐	☐	
Relatives aware of discharge	☐	☐	Please note here if any other tasks required prior to discharge
Social/ Support Services required and contacted	☐	☐	
SAS transport required and ref no	☐	☐	Print name
Other means of transport arranged by nurse	☐	☐	

Nursing Notes

Date and Time		Print Name and Signature
26/6/14	Taken through to room. Not responding.	
	When being spoken to.	[illegible]
	Awaiting review by doctor.	
	(Wearing red ~~clear~~ jacket and blue jeans)	
2355.	Awaiting IHTT.	
0300.	remains awaiting IHTT.	
	Called and will attend dept in next 1°.	

Emergency Department - Active Care

I have evaluated and deemed that the frequency of care delivery over the next work shift, based on the patient's most critical need should be every:

(Please circle) ½ hour 1hour 2 hours

Signed ..... Name .....

Patient Addressograph Label

			Time							
	1.	**PAIN: Assess and address** If in pain inform registered nurse **Y or N/A**								
S	2.	**SKIN INSPECTION** A. Pressure areas checked:								
		B. Redness (R) / Discolouration (D) / Pressure Ulcer (PU)								
K	3.	**KEEP MOVING:** A. Have you moved or walked **Y / N / I (independent)**								
		B. Trolley Right side (30° tilt) – R Left Side (30° tilt) – L Back– B								
		C. Chair Assist to walk, stand or tilt **(W /ST/ T)**								
I	4.	**ELIMINATION:** Do you need the toilet? I = Independent A = Assistance given IC = patient incontinent of urine/faeces								
N	5.	**FOOD, FLUIDS AND NUTRITION:** Is the patient nil by mouth? **Y / N** (consider mouth care)								
		Encourage the patient to drink? **(If appropriate) Y / N / N/A**								
		Food, snack or supplement taken? **(If appropriate) Y / N / N/A**								
	6.	**ENVIRONMENT:** Is the patient able to call for assistance? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the trolley in lowest position?								
	7.	**INFORMATION: Ask:** Is there anything else I can help you with? Inform patient of the time of return.								
	8.	**ESCALATION:** Escalate any issues to the Registered Nurse / Dr **Y / N/A**								
			Nurse Initials							

USE FOLLOWING CODE	Specialist Pressure Redistributing equipment	Variations			
V = Variant **I = Independent** **NT = No thanks**	☐ Repose Mattress ☐ Moving and handling aids ☐ Other:	Time	No.	Variation	Signed

Waterlow Pressure Area Risk Assessment

Build/Weight		Skin Type/Visual Risk Areas		Sex/Age		Special Risks - Tissue Malnutrition	
Average (BMI 20-24.9)	0	Healthy	0	Male	1	Multiple organ failure/ Terminal cachexia	8
Above Average (BMI 25-29.9)	1	Tissue Paper (thin/fragile)	1	Female	2		
Obese (BMI > 30)	2	Dry (appears flaky)	1	14-49	1	Single organ failure	5
Below Average (BMI < 20)	3	Oedematous (puffy)	1	50-64	2	Peripheral Vascular Disease	5
Continence		Clammy /pyrexia	1	65-74	3	Anaemia = Hb < 8	2
Complete/Catheterised	0	Discoloured (brusing/mottled)	2	75-80	4	Smoking	1
Incontinent urine	1			81+	5	**Neurological Deficit**	
Incontinent faeces	2	Broken (established ulcer)	3	**Nutritional Element**		Diabetes/MS/CVA Motor or sensory paraplegia (Max 6)	4-6
Doubly Incontinent (urine and faeces)	3	**Mobility**		Unplanned weight loss in past 3-6 months < 5% Score 0 5-10% Score 1 > 10% Score 2			
		Fully mobile	0				
Special Risks – Surgery/Trauma		Restless/Fidgety	1			**Special Risks - Medication**	
On table > 6 hours	8	Apathetic (sedated/depressed/ reluctant to move)	2			Cytotoxic, anti-inflammatory, long term/high dose steroids (Max 4)	4
Orthopaedic / below waist/Spinal (up to 48 hrs post-op)	5			BMI > 20 Score 0 BMI 18.5-20 Score 1 BMI < 18.5 Score 2			
On table > 2 hours (up to 48 hrs post op)	5	Bed bound (unconscious/unable to change position/traction)	4			Risk Score 10+= 'At risk' 15+= 'High Risk' 20+= 'Very High Risk'	
		Chair Bound	5	Patient acutely ill or no nutritional intake > 5 days	2		

Patient's Initial Waterlow Score = If Score ≥10 Complete the Adapted Waterlow Pressure Area Risk Assessment Chart

Patient Addressograph Label

Nursing Notes

Date and Time		Print Name and Signature

CALLED 0325 NO REPLY

CWA

NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

Affix Label

CHI: 1203893450

Royal Alexandra Hospital

Total Att: **49**

12 Mth Att: **12**

Title: **MR**

WEIR **James**

DOB: **12/03/1989** Age: **24y** Sex: **Male**

1/7 17 ABERCORN STREET
Paisley
Renfrewshire
PA3 4AA
07837 232 306

Next of kin: **WALKER, Craig**
Relationship: **Brother**
07837 232306

GP: **CJ Johnstone**
0141 889 3732

Attendance Date: **01/02/2014** Arrival Time: **02:54**

Registration Time: **02:54** Date of Incident: **01/02/2014**

Major Incident Desc:

Reason for Attendance: **I side chest pain**

Affix Label

Nursing Assessment

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

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

Presenting Complaint:

Observation Date: **01/02/2014 02:56** Nurse name: **Nurse Morag Smith**

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

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

GCS	
Eyes	
Motor	
Verbal	
Total	

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

Nursing Notes: **chest pain tonight. worse on inspiration/ coughing**

Child Assessment Questionnaire

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

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

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

DO NOT WRITE HERE PLEASE

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

Date	CLINICAL NOTES
	Seen by (Dr) Time seen

Date	CLINICAL NOTES

Discharge Codes (Please CIRCLE)					Discharge date	
1. Admission	2. Discharge	3. Refer to GP	4. Transfer to other (see below)			
5. Died	6. Refer to OP Clinic (see below)		7. Irregular Discharge	8. D.O.A.	Discharge time	

Ward number (if admitted):	Transfer to hospital:	Consultant If admitted):

Follow up	Arranged			Not arranged			To be arranged	
Clinic referred to	A&E	Hand injury	Fracture	Pop Check	Medical	Surgical	ENT	Others (specify):

Discharge Prescription Packs

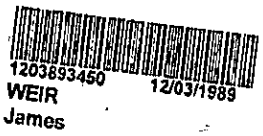
Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Frequency	Signature	Given By

Designed by Medical Illustration Services ref 243836

NEWS – National Early Warning Score

NHS
Greater Glasgow and Clyde

Name
Address



CHI No.
DoB

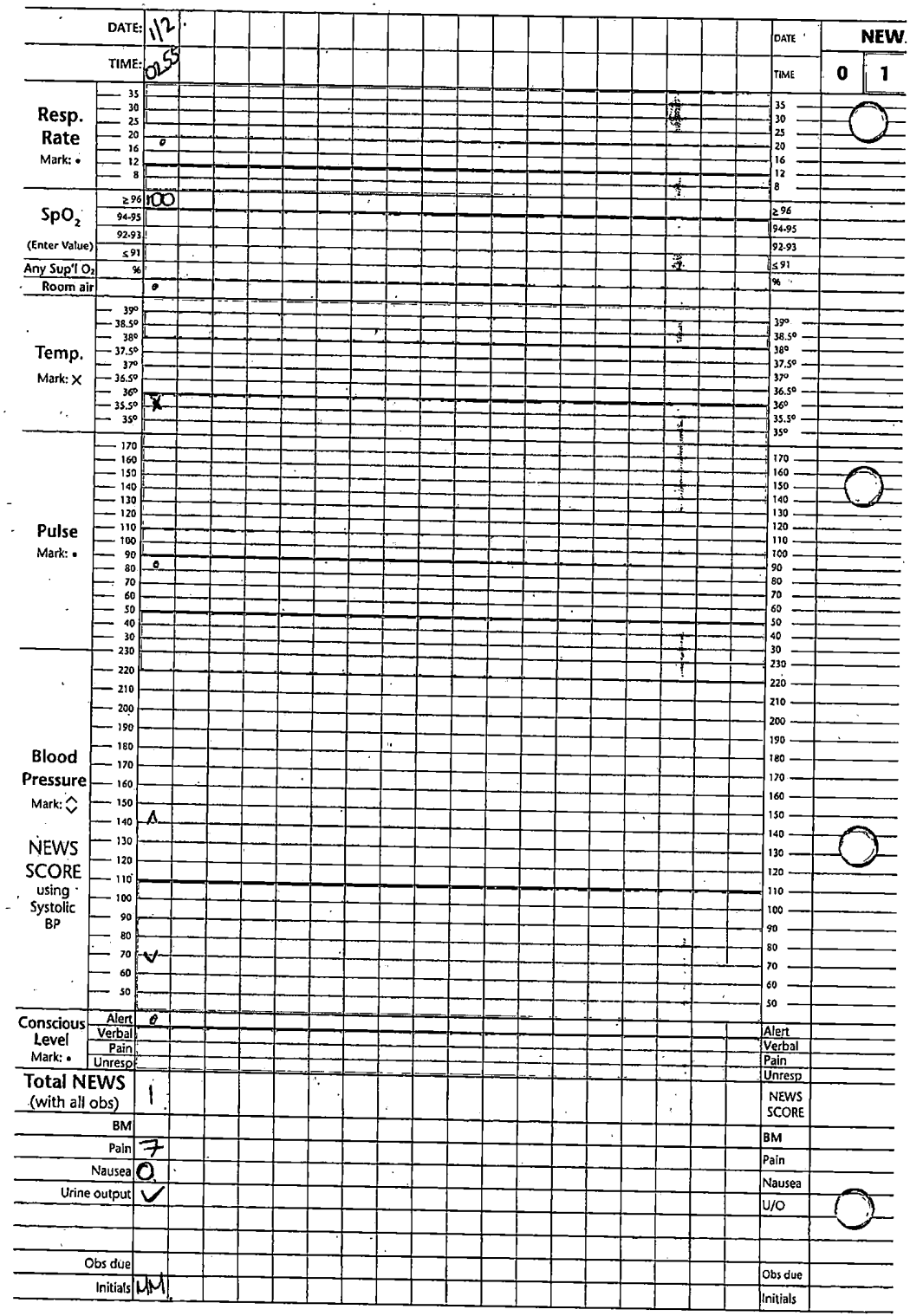
	Date	Ward
Admitted		
Transferred		
Transferred		

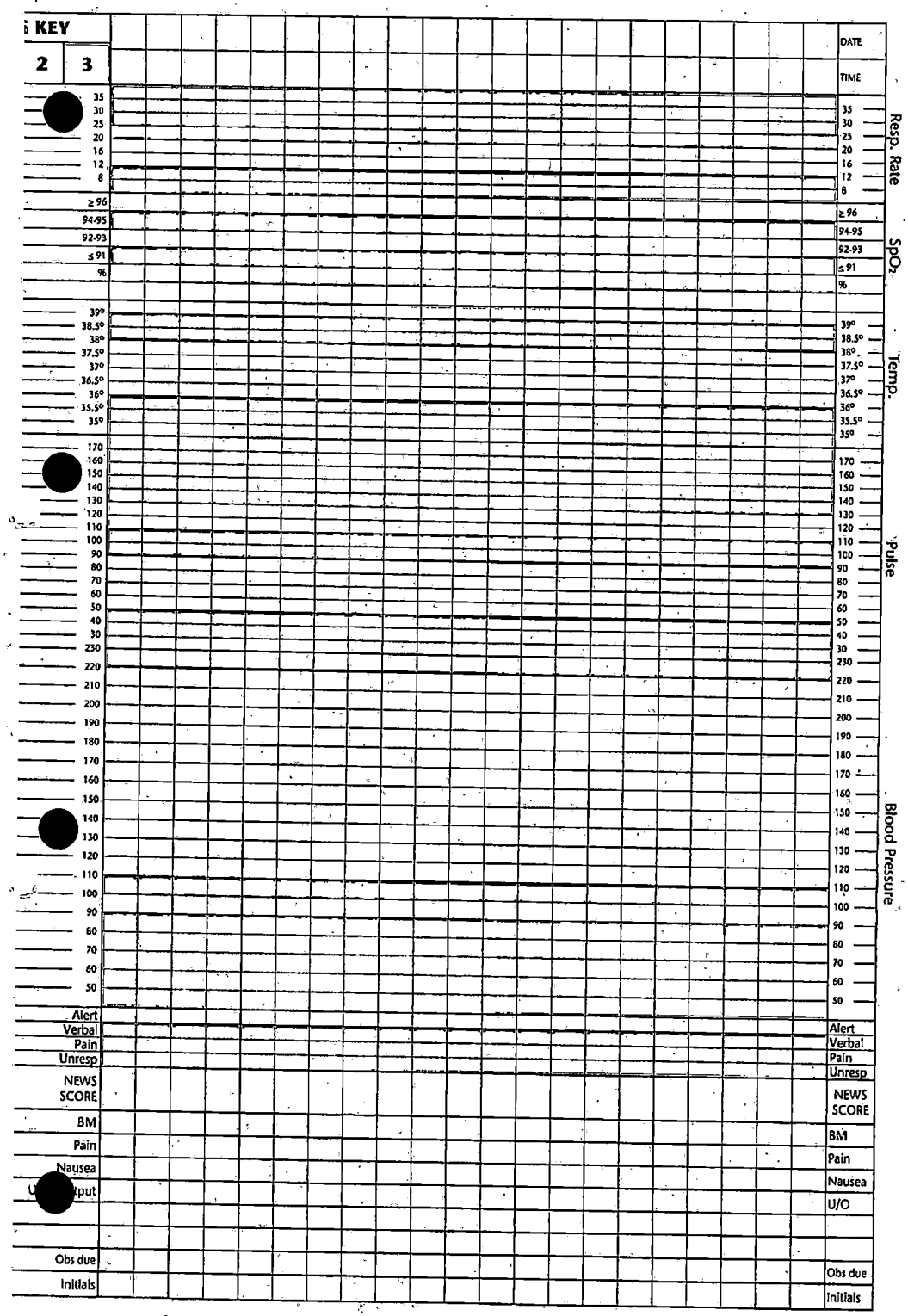
Physiological Parameter	NEWS – NHS Early Warning Score						
	3	2	1	0	1	2	3
Respiration Rate	≤8		9-11	12-20		21-24	≥25
Oxygen Saturations	≤91	92-93	94-95	≥96			
Any Supplemental Oxygen		Yes		No			
Temperature	≤35.0°		35.1-36.0°	36.1-38.0°	38.1-39°	≥39.1°	
Pulse	≤40		41-50	51-90	91-110	111-130	≥131
Systolic BP	≤90	91-100	101-110	111-219			≥220
Conscious Level				A			V, P or U

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

See NEWS Actions Reference Tool for local escalation policy

NEWS Score	Frequency of Monitoring	Clinical Response
0	Minimum 12 hourly	• Continue routine NEWS monitoring with every set of observations.
Aggregate 1- 4	Minimum 4 hourly	• Inform trained nurse. • Trained Nurse assessment: - Assess the patient - Review frequency of monitoring required - Assess need for escalation of clinical care and direct as appropriate.
Aggregate 5 or more or 3 in one parameter	Increased frequency to a minimum of 1 hourly	• Trained Nurse assessment. • Inform medical team caring for the patient. • Urgent assessment by a medical / surgical / nursing team with core competencies to assess acutely ill patients. • Consider level of monitoring required in relation to clinical care.
Aggregate 7 or more	Continuous monitoring of vital signs	• Trained Nurse to assess immediately. • Inform medical team caring for the patient – this should be at least senior medical staff level. • Emergency assessment by a clinical team with core competencies in the assessment of critically ill patients. This team will have critical care competencies and a practitioner/s with advanced airway skills and resuscitation skills. • Consider referral to high dependency or ITU.


DATE: 1/2
TIME: 0155
NEW
0 1
Resp. Rate
Mark: •
SpO2
(Enter Value)
Any Sup'l O2
Room air
Temp.
Mark: X
Pulse
Mark: •
Blood Pressure
Mark: ◇
NEWS SCORE using Systolic BP
Conscious Level
Mark: •
Alert
Verbal
Pain
Unresp
Total NEWS (with all obs)
BM
Pain
Nausea
Urine output
Obs due
Initials
DATE
TIME
NEWS SCORE
BM
Pain
Nausea
U/O
Obs due
Initials


KEY
2
3
DATE
TIME
Resp. Rate
35
30
25
20
16
12
8
SpO2
≥ 96
94-95
92-93
≤ 91
%
Temp.
39°
38.5°
38°
37.5°
37°
36.5°
36°
35.5°
35°
Pulse
170
160
150
140
130
120
110
100
90
80
70
60
50
40
30
230
220
210
200
190
180
170
160
150
140
130
120
110
100
90
80
70
60
50
Blood Pressure
Alert
Verbal
Pain
Unresp
NEWS SCORE
BM
Pain
Nausea
U/O
Obs due
Initials

Neurological Observations

| | | |

E-Pacer PATIENT REPORT

Time	02:48	Date	01/02/2014

PATIENT AND INCIDENT DETAILS

Incident number	CR000082671 001
Name	JAMES WEIR
Age	24Y
Date of birth	12/03/1989
Gender	Male
CHI number	1203893450
Incident location	1/7 17 ABERCORN STREET PAISLEY
Incident post code	PA3 4AA
Incident type	EMG
Call received	01/02/2014, 02:02
Call passed	01/02/2014, 02:09
Crew mobile	01/02/2014, 02:10
Crew at scene	01/02/2014, 02:34

PRIMARY SURVEY

RESPONSE	
AVPU	Alert
AIRWAY	
Airway assessment	Clear
BREATHING	
Breathing rate	Normal
Respiratory rate	
CIRCULATION	
Pulse rate	Fast
Most peripheral pulse found	Radial
Cap refill rate	
Skin colour	Normal

PATIENT CONSENT

Patient consent	Treatment benefits explained, Risks of condition explained, Risk of refusal explained, Capacity to understand risks and treatment

AMPDS

Dispatch code	33C06	Emergency response req'd
Final code	10A01	Chest Pains, Breathing normally 12-34 rpm

GCS

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

VITAL SIGNS

Time hr : min	Pulse bpm	Pulse rhythm	Resp. rpm	BP mm Hg	Cap refill (secs)	Peak flow %	Blood sugar mmol / l	Pain score	Temp °C	SpO2 %	GCS Total	NEWS	RTS	ECG	Sepsis
02 35	112	Reg	18	127 / 96	<2 secs	-	6.9	7/10	36.3	100	15	2	7.6	NSR	1
-	-	-	-	- / -	-	-	-	-	-	-	-	-	-	-	0

SEPSIS

Sepsis: Pneumonia	
Sepsis: UTI	
Sepsis: Other infection	
Sepsis: Abdo pain	
Sepsis: Diarrhoea	
Sepsis: Abdo distension	
Sepsis: Meningitis	
Sepsis: Cellulitis	
Sepsis: Septic arthritis	
Sepsis: Wound infection	
Sepsis: Infected indwelling device	

EYES AND PUPIL SIZE AND REACTION

	Left	Right
Pupil size	Normal	Normal
Pupil reaction	Normal	Normal

AMPLE

Allergies	
Other allergies	PENICILLAN
Medication	IBUPROFEN
Past history	KIDNEY STONES, GASTRITIS.
Last eaten	½ hr
Events prior	

FINAL OBSERVATION AND COMMENTS

PATIENT TOOK L/SIDED CHEST PAIN WHILE AT REST ABOUT 8PM TONIGHT. WORSE ON INHALATION ND WHEN LIFTING LEFT ARM. NO HISTORY OF SAME. LUNGS CLEAR. SOME LIFTING AT WORK. NO DRUGS OR ALCOHOL TAKEN.	
Report ID	9b01f3ea-ebaf-4770-bd0e-d8f29ce54f8b

NHS GGC Hospitals, Emergency Department

CwA

NHS Greater Glasgow and Clyde

CHI: 1203893450

Royal Alexandra Hospital

Total Att: 48

12 Mth Att: 11

Title: MR

WEIR **James**

DOB: 12/03/1989 Age: 24y Sex: Male

1/7 17 ABERCORN STREET
Paisley
Renfrewshire
PA3 4AA
07837 232 306

Next of kin: WALKER, Craig
Relationship: Brother
07837 232306

GP: CJ Johnstone
0141 889 3732

Attendance Date: 27/01/2014 Arrival Time: 19:58

Registration Time: 19:58 Date of Incident: 27/01/2014

Major Incident Desc:

Reason for Attendance: **mental health issues**

Nursing Assessment

Alerts: Not Recorded Allergies: Not Recorded Pain Score:

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

Presenting Complaint:

Observation Date: 27/01/2014 20:14 Nurse name: Nurse Emma Johnston

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

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

GCS	
Eyes	
Motor	
Verbal	
Total	

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

Nursing Notes:

97607

Child Assessment Questionnaire

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

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

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

DO NOT WRITE HERE PLEASE

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

Date	CLINICAL NOTES
	Seen by (Dr) Time seen

Date	CLINICAL NOTES

Discharge Codes (Please CIRCLE)					Discharge date	
1. Admission	2. Discharge	3. Refer to GP	4. Transfer to other (see below)			
5. Died	6. Refer to OP Clinic (see below)		7. Irregular Discharge	8. D.O.A.	Discharge time	

Ward number (if admitted):	Transfer to hospital:	Consultant If admitted):

Follow up	Arranged		Not arranged				To be arranged
Clinic referred to	A&E	Hand injury	Fracture	Pop Check	Medical	Surgical	ENT	Others (specify):

Discharge Prescription Packs

Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Frequency	Signature	Given By

Designed by Medical Illustration Services ref 243836

NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

Name	
Address	
	1203893450 12/03/1989 WEIR James
CHI No.	
DoB	

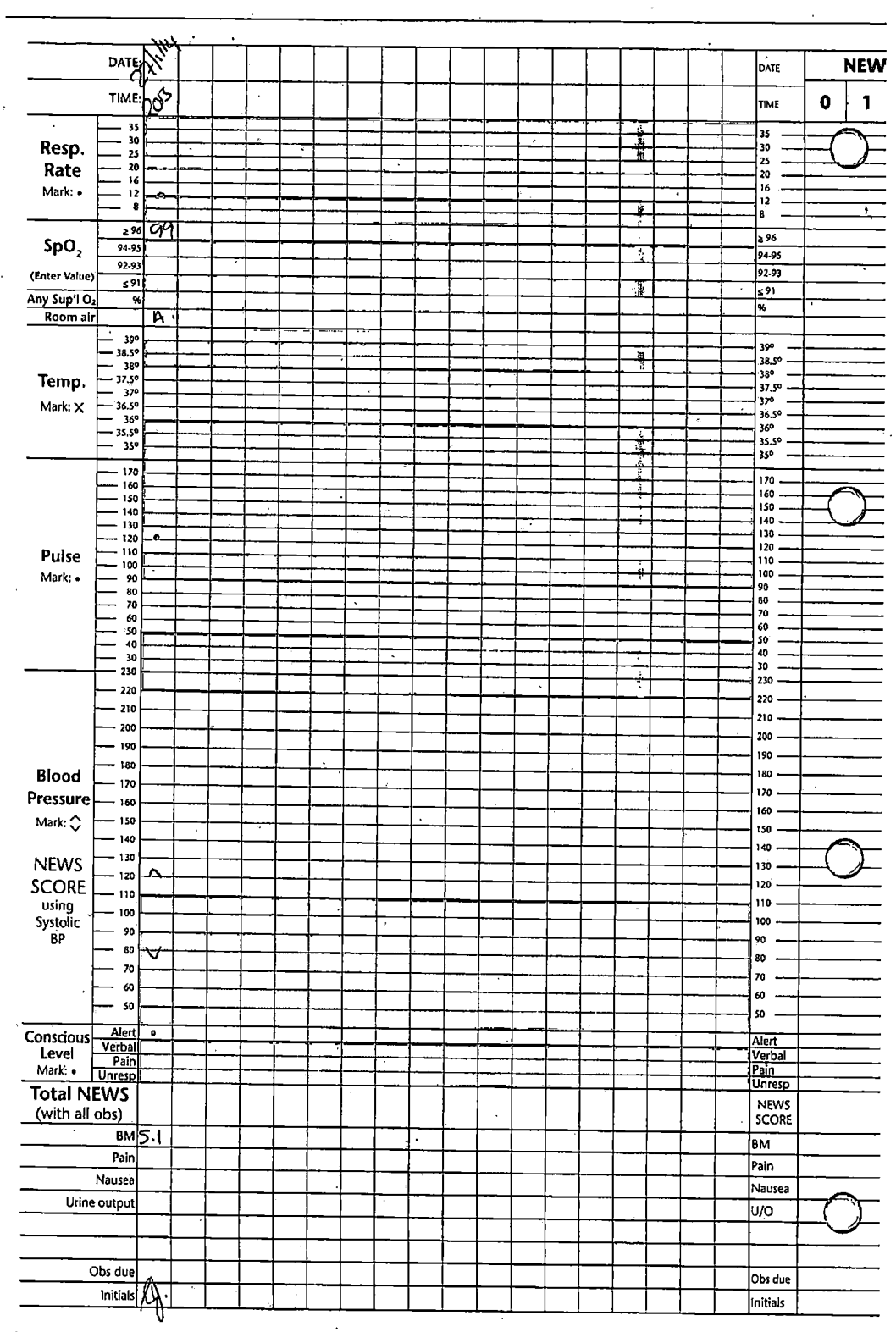
	Date	Ward
Admitted		
Transferred		
Transferred		

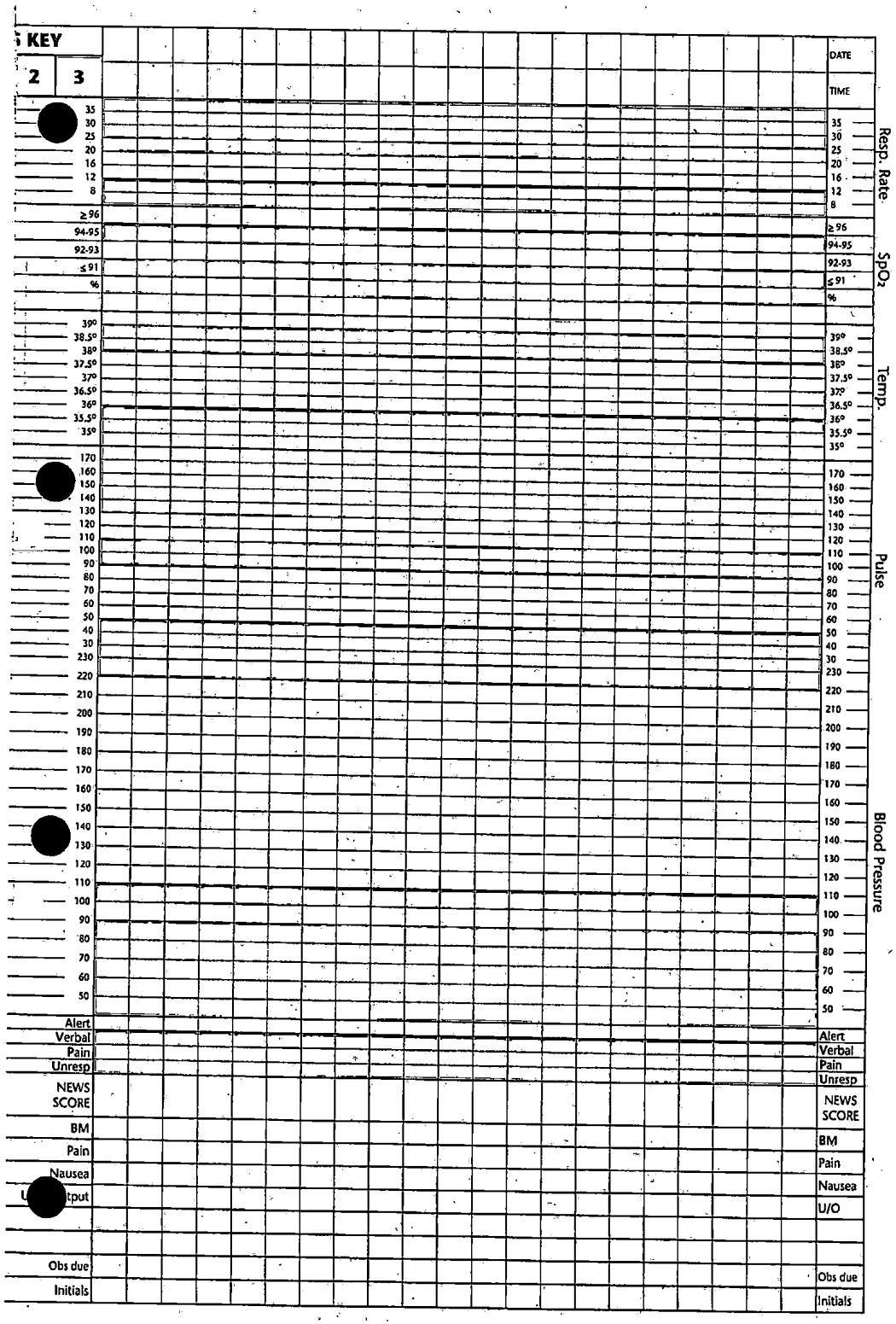
Physiological Parameter	NEWS – NHS Early Warning Score						
	3	2	1	0	1	2	3
Respiration Rate	≤8		9-11	12-20		21-24	≥25
Oxygen Saturations	≤91	92-93	94-95	≥96			
Any Supplemental Oxygen		Yes		No			
Temperature	≤35.0°		35.1-36.0°	36.1-38.0°	38.1-39°	≥39.1°	
Pulse	≤40		41-50	51-90	91-110	111-130	≥131
Systolic BP	≤90	91-100	101-110	111-219			≥220
Conscious Level				A			V, P or U

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

See NEWS Actions Reference Tool for local escalation policy

NEWS Score	Frequency of Monitoring	Clinical Response
0	Minimum 12 hourly	• Continue routine NEWS monitoring with every set of observations.
Aggregate 1- 4	Minimum 4 hourly	• Inform trained nurse. • Trained Nurse assessment: - Assess the patient - Review frequency of monitoring required - Assess need for escalation of clinical care and direct as appropriate.
Aggregate 5 or more or 3 in one parameter	Increased frequency to a minimum of 1 hourly	• Trained Nurse assessment. • Inform medical team caring for the patient. • Urgent assessment by a medical / surgical / nursing team with core competencies to assess acutely ill patients. • Consider level of monitoring required in relation to clinical care.
Aggregate 7 or more	Continuous monitoring of vital signs	• Trained Nurse to assess immediately. • Inform medical team caring for the patient – this should be at least senior medical staff level. • Emergency assessment by a clinical team with core competencies in the assessment of critically ill patients. This team will have critical care competencies and a practitioner/s with advanced airway skills and resuscitation skills. • Consider referral to high dependency or ITU.


DATE
TIME
Resp. Rate
Mark: •
SpO2
(Enter Value)
Any Sup'l O2
Room air
Temp.
Mark: X
Pulse
Mark: •
Blood Pressure
Mark: ^ v
NEWS SCORE using Systolic BP
Conscious Level
Mark: •
Alert
Verbal
Pain
Unresp
Total NEWS (with all obs)
BM
Pain
Nausea
Urine output
Obs due
Initials
NEW
0
1
NEWS SCORE
U/O

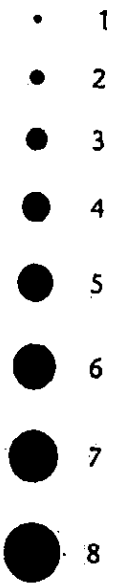

KEY
2
3
DATE
TIME
Resp. Rate
SpO2
Temp.
Pulse
Blood Pressure
Alert
Verbal
Pain
Unresp
NEWS SCORE
BM
Pain
Nausea
U/O
Obs due
Initials

Neurological Observations

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

Glasgow Coma Scale

Pupil size (mm)



Pain Score

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

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

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

Management Plan and Patient Exclusions

Date and Time	Notes	Signed

Redesigned by Medical Illustration Services • 231261

Emergency Department Nursing Documentation

Pa [barcode] abel
1203893450 12/03/1989
WEIR
James

Presenting Complaint - Collapse in Close. Vomited. Intoxicated. Taken Ecstacy and Smoked Exodus

Date & Time - 27/1/14 202

Named Nurse(s):

Patient preparation
(Please tick when completed)

Prepare patient for examination	☐
Provide blankets if required	☐
Clothing bagged, labelled & stored under trolley	☐

Communication
(Please tick when completed)

Communication Aids (spectacles / hearing aid)	☐
Relatives present?	☐
Relatives / NOK informed	☐
Interpreter required	☐
Telephone interpretation required	☐

Observations and Investigations
(Please tick when completed)

Vital Signs recorded on NEWS chart & NEWS score recorded. Record Pain, blood sugar and neuro obs on NEWS chart if appropriate. ☐	IV Cannula (if required) dated & timed ☐
Peak Flow 1. 2. 3. ☐	Blood samples taken ☐
12 Lead ECG ☐	Urinalysis & Specimen if indicated ☐
Cardiac Monitoring ☐	*Results:*
X-rays performed ☐	HCG specimen if indicated ☐
Other: please add ☐	*+ve* ☐ *-ve* ☐ *Strip Lot no:*
	Weight ☐

Screening Tools
(Please tick when completed)

SEPSIS risk? SIRS Criteria 2 or more and suspicion of infection	☐	Preliminary Pressure Ulcer Risk Assessment. The patient can reposition themselves whilst in the department?	Y / N
AMT 4 (if >65 years) SCORE	/4	There is no reported skin damaged other than presenting trauma?	Y / N
At risk of falls? (clinical judgement) (consider alcohol, mobility, age, illness, cognitive impairment etc). *If at risk complete risk assessment*	☐	The person is fully continent? *If NO to any of the above initiate Waterlow risk assessment (within 4 hrs)*	Y / N
Mental Health Triage Assessment	☐	Waterlow Score *If >10 commence Active Care*	☐
Child Protection considered (in line with policy)	☐	Active Care (clinical judgement) (include all trolley patients at risk of pressure ulcers and all trolley patients in department for >4hrs) *Record on Active Care Chart*	☐
GMAWS	☐	Pressure damage identified on arrival in ED is documented in clinical notes	☐
Swallow test (if CVA/stroke)	☐	Grade 3 or 4 Pressure Ulcers are reported on DATIX	☐

Pause for Transfer
(Please tick when completed)

	Tick when completed	N/A	Notes
Relatives informed	☐	☐	Information on discussion with relatives
Cannula dated and timed	☐	☐	
Name band	☐	☐	
AMT4	☐	☐	
NEWS chart	☐	Always	
Prescriptions signed — Infusions	☐	☐	
Drugs	☐	☐	
Fluids	☐	☐	
GMAWS	☐	☐	
Belongings (including patient's medications)	☐	Always	Please note here if any other tasks required prior to transfer
Bed requested, accepted and ward informed.	☐	Always	
Notes: medical notes, GP letter, PRF	☐	Always	
Investigations — CXR reviewed	☐		
ECG reviewed	☐	☐	Print name
Bloods sent	☐	☐	
Bloods reviewed	☐	☐	
Patient on O_2: cylinder checked	☐	☐	
Patients requiring analgesia: sufficient	☐	☐	

Patient Addressograph Label

Pause for Discharge (Please tick when completed)	Tick when completed	N/A	Notes
Advice leaflets given	☐	☐	Information on discussion with relatives
Belongings (including patient's medications)	☐	Always	
New medications explained	☐	☐	
Cannula Removed	☐	☐	
Relatives Aware of Discharge	☐	☐	Please note here if any other tasks required prior to discharge
Social Support Services required & contacted	☐	☐	
SAS Transport required & ref no	☐	☐	Print name
Other means of transport arranged by nurse	☐	☐	

Nursing Notes

Date & Time		Print Name & Signature
27/1/14	2022 Pt Refusing treatment and leaving dept	

E-Pacer PATIENT REPORT

Time	19:54	Date	27/01/2014

PATIENT AND INCIDENT DETAILS

Incident number	CR000073695.001
Name	JAMES WEIR
Age	20 year(s)
Date of birth	12/03/1989
Gender	Male
Incident location	1/1 4 GORDON STREET PAISLEY
Incident post code	PA1 1XE
Incident type	EMG
Call received	27/01/2014, 19:00
Call passed	27/01/2014, 19:09
Crew mobile	27/01/2014, 19:10
Crew at scene	27/01/2014, 19:32
Crew left scene	27/01/2014, 19:49
Patient at hospital	27/01/2014, 19:53
Receiving hospital and department	RAHP Royal Alexandra - Paisley

PRIMARY SURVEY

RESPONSE	
AVPU	Alert
AIRWAY	
Airway assessment	Clear
BREATHING	
Breathing rate	Normal
Respiratory rate	

CIRCULATION

Pulse rate	Normal
Most peripheral pulse found	Radial
Cap refill rate	
Skin colour	Pale
Skin texture	Dry

PATIENT CONSENT

Patient consent	Treatment benefits explained, Risks of condition explained, Risk of refusal explained, Capacity to understand risks and treatment

AMPDS

Dispatch code	26D01	Sick Person - Not Alert
Final code	23B01	Overdose without priority symptoms

GCS

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

VITAL SIGNS

Time hr : min	Pulse bpm	Pulse rhythm	Resp. rpm	BP mm Hg	Cap refill (secs)	Peak flow %	Blood sugar mmol / l	Pain score	Temp °C	SpO2 %	GCS Total	NEWS	RTS	ECG	Sepsis
19:34	93	-	18	130 / 88	<2 secs		4.0	-	36.0	99	15	1	7.6	-	0
-	-	-	-	- / -	-	-	-	-	-	-	-	-	-	-	0

SEPSIS

Sepsis: Pneumonia	
Sepsis: UTI	
Sepsis: Other infection	
Sepsis: Abdo pain	
Sepsis: Diarrhoea	
Sepsis: Abdo distension	
Sepsis: Meningitis	
Sepsis: Cellulitis	
Sepsis: Septic arthritis	
Sepsis: Wound infection	
Sepsis: Infected indwelling device	

EMERGENCY SERVICES ON SCENE

Paramedic	Police

PATIENT HANDOVER

On arrival at scene	Seated
Scene removal	Walking
Transportation	Seated
Care delivery at hospital	Walking
Time of handover	19:54

FINAL OBSERVATION AND COMMENTS

PT DRINKING ALCOHOL 3X BUCKFAST (HALF) TABLET ? ROLEX ECSTASY , SMOKED HERBAL LEGAL HIGH (EXODUS) PT FOUND COLLAPSD STATE , HAD VOMITED	
Report ID	d0a97670-6a98-44de-a830-d05758353067

NHS GCC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

Rm 10 PWA

Affix Label

IDH	RAH	RHSC	GRI	WIG	VI	VIMIU	Stob	VOL	SGH

CHI: 1203893450

Royal Alexandra Hospital

Total Att: **44**

12 Mth Att: **10**

Title: **MR**

WEIR

James

DOB: **12/03/1989**

Age: **24y**

Sex: **Male**

FLAT 2/1
94 PAISLEY RD
Renfrew
Renfrewshire
PA4 8HD

Next of kin: **WALKER, Craig**
Relationship: **Brother**
07837 232306

GP: **A Sunderland**
0141 314 4645

Attendance Date: **09/10/2013** Arrival Time: **20:25**

Registration Time: **20:25** Date of Incident: **09/10/2013**

Major Incident Desc:

Reason for Attendance: **suicidal**

Nursing Assessment

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

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

Presenting Complaint:

Observation Date: **09/10/2013 20:51**

Nurse name: **Nurse Jackie Boyd**

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

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

Visual Acuity	
Left	
Right	
Corrected?	

GCS	
Eyes	
Motor	
Verbal	
Total	

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

Nursing Notes: **suicidal**

97607

Child Assessment Questionnaire

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

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

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

DO NOT WRITE HERE PLEASE

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

Date	CLINICAL NOTES
9/10/15	Seen by (Dr) WILSON Time seen 2215 see D prof

Date	CLINICAL NOTES

Discharge Codes (Please CIRCLE)

1. Admission 2. Discharge 3. Refer to GP 4. Transfer to other (see below)
5. Died 6. Refer to OP Clinic (see below) 7. Irregular Discharge 8. D.O.A.

Discharge date	
Discharge time	

Ward number (if admitted):	Transfer to hospital:	Consultant If admitted):

Follow up	Arranged			Not arranged			To be arranged	
Clinic referred to	A&E	Hand injury	Fracture	Pop Check	Medical	Surgical	ENT	Others (specify):

Discharge Prescription Packs

Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Frequency	Signature	Given By

Designed by Medical Illustration Services ref 243836

NEWS – National Early Warning Score

NHS
Greater Glasgow and Clyde

Name
Address

1203893450 12/03/1989
WEIR
James

CHI No.
DoB

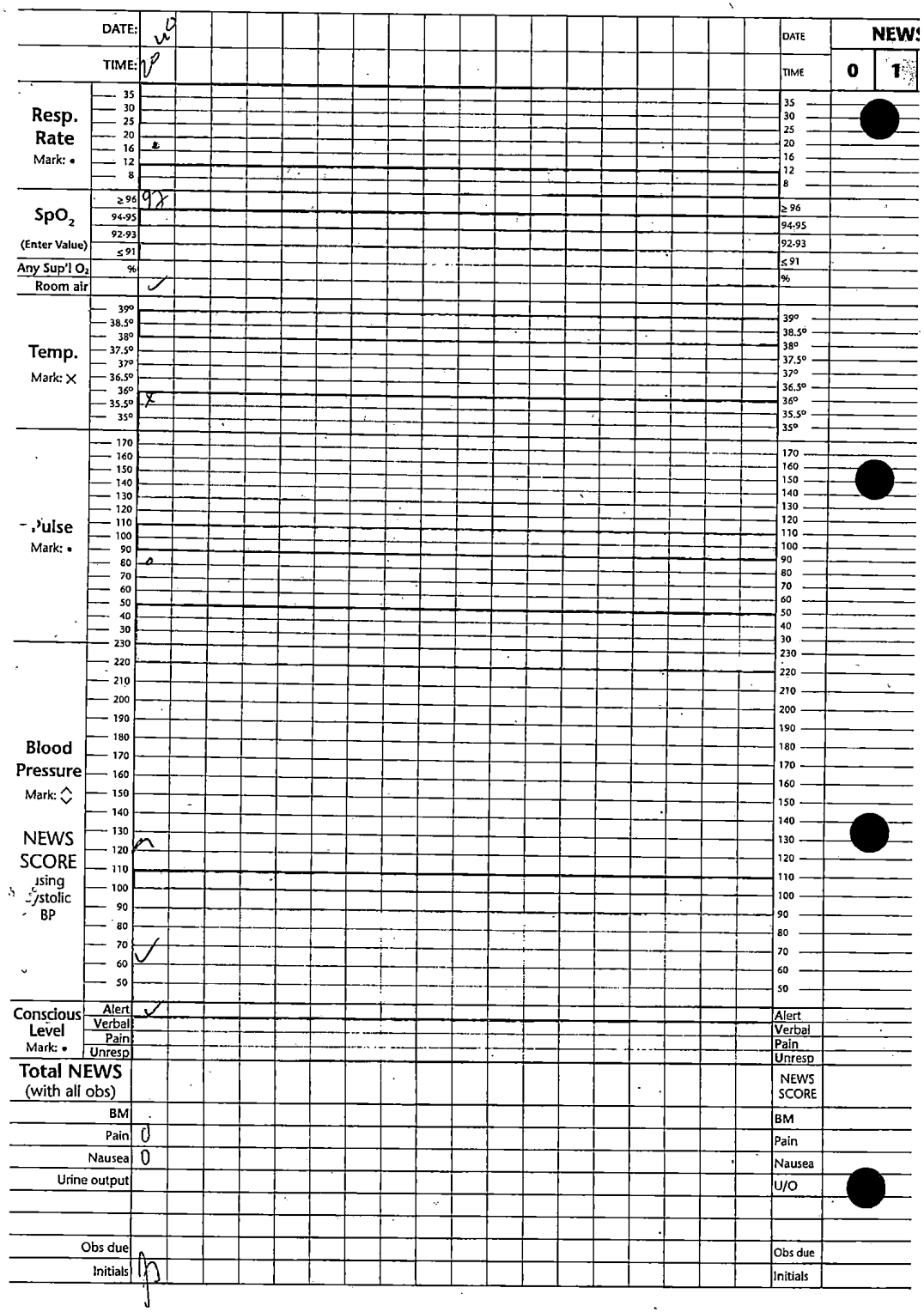
	Date	Ward
Admitted		
Transferred		
Transferred		

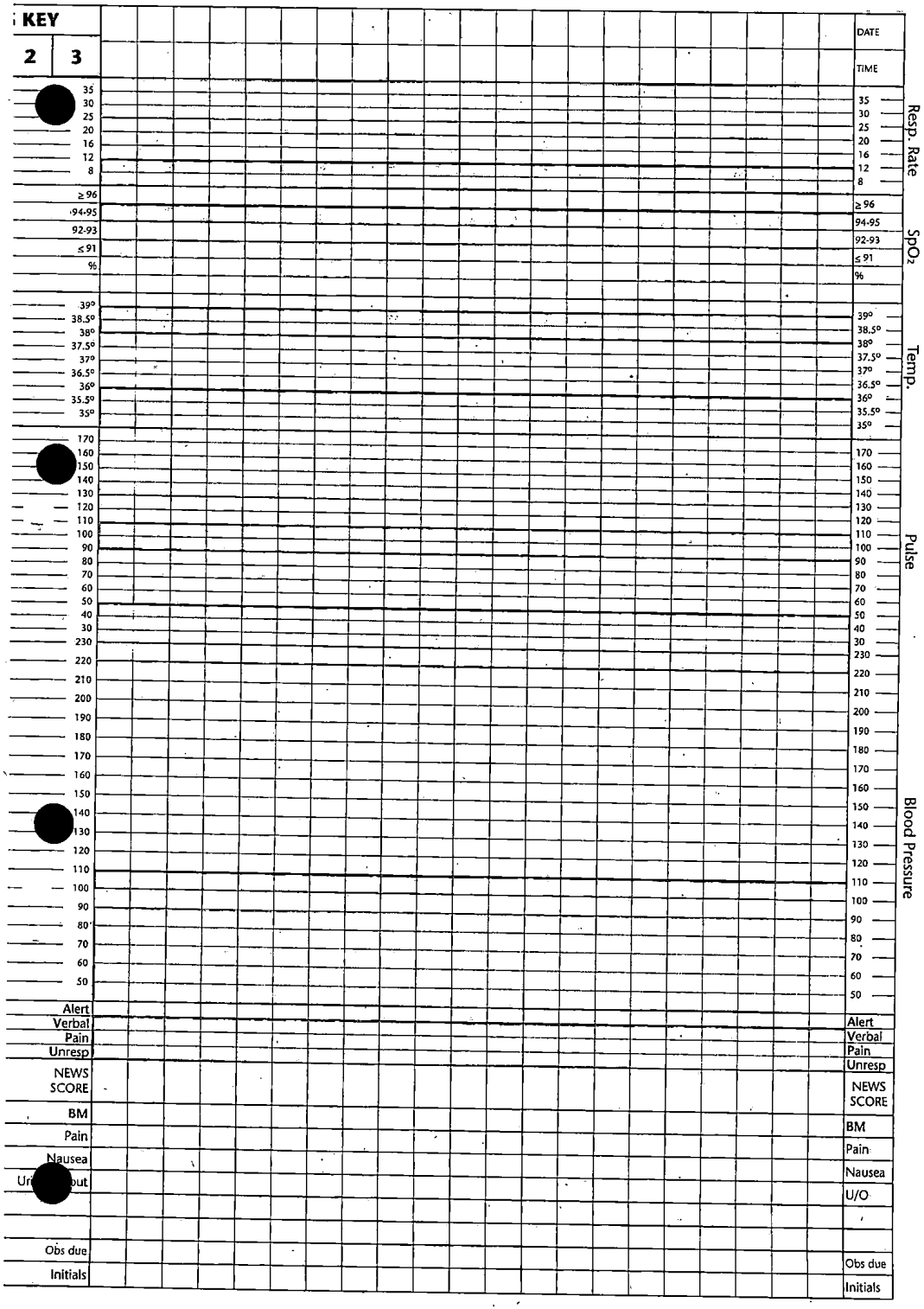
Physiological Parameter	NEWS – NHS Early Warning Score						
	3	2	1	0	1	2	3
Respiration Rate	≤8		9-11	12-20		21-24	≥25
Oxygen Saturations	≤91	92-93	94-95	≥96			
Any Supplemental Oxygen		Yes		No			
Temperature	≤35.0°		35.1-36.0°	36.1-38.0°	38.1-39°	≥39.1°	
Pulse	≤40		41-50	51-90	91-110	111-130	≥131
Systolic BP	≤90	91-100	101-110	111-219			≥220
Conscious Level				A			V, P or U

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

See NEWS Actions Reference Tool for local escalation policy

NEWS Score	Frequency of Monitoring	Clinical Response
0	Minimum 12 hourly	• Continue routine NEWS monitoring with every set of observations.
Aggregate 1- 4	Minimum 4 hourly	• Inform trained nurse. • Trained Nurse assessment: - Assess the patient - Review frequency of monitoring required - Assess need for escalation of clinical care and direct as appropriate.
Aggregate 5 or more or 3 in one parameter	Increased frequency to a minimum of 1 hourly	• Trained Nurse assessment. • Inform medical team caring for the patient. • Urgent assessment by a medical / surgical / nursing team with core competencies to assess acutely ill patients. • Consider level of monitoring required in relation to clinical care.
Aggregate 7 or more	Continuous monitoring of vital signs	• Trained Nurse to assess immediately. • Inform medical team caring for the patient – this should be at least senior medical staff level. • Emergency assessment by a clinical team with core competencies in the assessment of critically ill patients. This team will have critical care competencies and a practitioner/s with advanced airway skills and resuscitation skills. • Consider referral to high dependency or ITU.


DATE:
TIME:
Resp. Rate
Mark: •
35
30
25
20
16
12
8
SpO2
(Enter Value)
≥ 96
94-95
92-93
≤ 91
Any Sup'l O2
%
Room air
Temp.
Mark: ×
39°
38.5°
38°
37.5°
37°
36.5°
36°
35.5°
35°
Pulse
Mark: •
170
160
150
140
130
120
110
100
90
80
70
60
50
40
30
Blood Pressure
Mark: ◇
230
220
210
200
190
180
170
160
150
140
130
120
110
100
90
80
70
60
50
NEWS SCORE
using systolic BP
Conscious Level
Mark: •
Alert
Verbal
Pain
Unresp
Total NEWS (with all obs)
BM
Pain
Nausea
Urine output
Obs due
Initials
DATE
TIME
NEWS
0
1
NEWS SCORE
BM
Pain
Nausea
U/O
Obs due
Initials

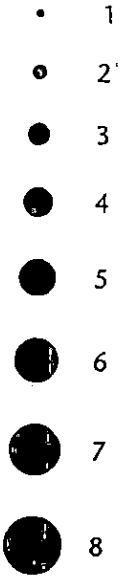

KEY
2
3
DATE
TIME
Resp. Rate
35
30
25
20
16
12
8
SpO2
≥ 96
94-95
92-93
≤ 91
%
Temp.
39°
38.5°
38°
37.5°
37°
36.5°
36°
35.5°
35°
Pulse
170
160
150
140
130
120
110
100
90
80
70
60
50
40
30
Blood Pressure
230
220
210
200
190
180
170
160
150
140
130
120
110
100
90
80
70
60
50
Alert
Verbal
Pain
Unresp
NEWS SCORE
BM
Pain
Nausea
U/O
Obs due
Initials

Neurological Observations

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

Glasgow Coma Scale

Pupil size (mm)



Pain Score

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

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

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

Management Plan and Patient Exclusions

Date and Time	Notes	Signed
20.50	Pt Threatening to jump out with Staff	
4/10/13	Pt Seeking Suicidal Alcohol on board	
	Pt Stays in Blue Triangle — They phoned Police	

Emergency Department
Mental Health Triage and Risk Assessment

NHS
er Glasgow
d Clyde

1203893450 12/03/1989
WEIR
James

Emergency Department Triage
(This side to be completed by triage nurse)

Patient Name _____

DoB _____ CHI _____

Triage Observations
(Document physiological measurements)

GCS	BM	HR	BP	RR	SaO_2	Temp

Accompanied by...
(Name/relationship/particular concerns)

Police

Or describe the patient's physical appearance/clothing if attending alone as they may leave before assessment

Is the patient a young person in foster care or in a residential care placement? Yes/No

Is the patient a carer for a child or for a dependent adult? Yes/No

Is there a child protection concern or concern for an adult at risk? Yes/No

Outline of Presentation
(Tick all those categories which apply and provide a brief summary)

Overdose – will require medical assessment	
Self-Injury - will require wound management	
Other Mental Health Presentation	✓

Psych Suicidal

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

Is the patient violent, aggressive or threatening?	Yes		(No)
Is the patient obviously distressed, markedly anxious or highly aroused?		(Yes)	No
Is the patient quiet and withdrawn?		Yes	(No)
Do you think the patient is behaving inappropriately to their situation?		Yes	(No)
Do you think the patient presents an immediate risk to you, to others, or to themselves?	Yes	?	No
Do you think the patient is likely to abscond prior to assessment?	Yes		(No)
Do you think the patient's presentation suggests either delusions or hallucinations?*	Yes		(No)
Do you think the patient's presentation suggests they feel their actions are being controlled?	Yes		(No)
Are you aware of a history of mental health problems or psychiatric illness?		Yes	(No)
Are you aware of a history of violence or self harm?		Yes	(No)
Is the patient currently expressing suicidal thoughts	(Yes)		No

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

Triage Risk Assessment
(Indicate an initial category of risk by circling one and selecting one or more risks)

High/Moderate/Low Risk
of self-harm/violence/absconding in department

Triage Category		
	2	high risk – supervised *and* in the department moderate risk – supervised *or* in the department low risk – can be asked to wait if necessary

Any responses in the first column
High Risk

Other patients can be categorized as
Moderate Risk

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

Immediate Management
(Print toxbase information and in paracetamol overdose document 4 hour time for samples)

Patient location, supervised by...			
Blood sample time?		Toxbase Information Printed?	

Print Name _____

Signature _____

Date _____ Time _____

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Emergency Department Mental Health Assessment

This MUST be completed by medical staff

Outline of current presentation and precipitating factors

Lives in homeless unit. Feeling suicidal. Planned to jump out of 4 storey window. Wrote a letter to key worker (suicide note) and left it → staff found letter and contacted police.
No obvious precipitating factors other than ~~drug use~~ ex partner gave BMH to daughter 2/52 ago and not seen daughter. Consumed ½ bottle of Diazepam tabs.

Previous mental health problems, self harm, addictions, medication etc

Schizophrenia
PTSD
depression

Other relevant information; relationships, finances, employment, housing, physical health, childcare etc

Lives in homeless unit. HCV positive with alcohol and drugs

Appearance	Behaviour	Speech
appropriately dressed	~~agitated~~ ~~aggressive~~ withdrawn upset	normal
Mood	**Thought**	**Insight**
low	psychotic thoughts suicidal threatening to commit suicide	poor insight

Risk Assessment

Based on clinical assessment, indicate category of risk of further episode of self-harm in the short term (= 48 hrs), considering any protective as well as precipitating factors.

High/Moderate/Low (circled) ~~Moderate~~ ~~Low~~

Summary and Plan for Further Assessment

Refer to liaison psychiatry, duty doctor, CPN service, CMHT, GP, addiction services, SWAEDs

Summary

Service Referred to	Time of Referral
psychiatry	2245

Discharge

Indicate the follow up plan, advice given and whether or not others informed on the decision

Follow up and advice	Carer informed

Name and Designation of Consultant or Middle-Grade Involved in Reviewing Patient	

Risk Factors (yes/no/unknown)

male gender	(y)	n	u
age >18 and <65	(y)	n	u
depression	(y)	n	u
alcohol or drug use	(y)	n	u
separated, widowed, divorced	y	(n)	u
suicide plan/concealment	(y)	n	u
evidence of psychosis	y	(n)	u
ongoing suicidal intent	(y)	n	u
lack of social support	(y)	n	u
chronic physical illness/pain	y	(n)	u
family history of suicide	y	(n)	u
family concerned about risk	y	(n)	u
disengaged/poor compliance	y	(n)	u
unemployed or retired	(y)	n	u
access to lethal means of harm	(y)	n	u
previous violent methods	y	(n)	u
history of self harm/overdose	(y)	n	u
previous psychiatric treatment	(y)	n	u
current psychiatric treatment	(y)	n	u
current use of benzodiazepines	y	n	(u)

If young people in foster or residential care are assessed, their social work team should be informed, (via standby SW if out-of-hours), *and* correspondence given to carers present.

Print Name [illegible]

Signature [illegible]

Date & Time 8/10/13 2300

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version 2.0 – February 2013.

Out-of-Hours Psychiatric Nursing Service

NURSING ASSESSMENT

PATIENT DETAILS

Date

Name JT 1203893450 12/03/1989 WEIR James

Address

Post Code Flat 2/1 94 Onslow Dr PA4 8HD.

DOB 12-03-1989.

Tel No

PIMS No

GP Name A Sutherland.

GP Address

314 4645.

Known to Service: YES ☐ NO ☑

If so, Consultant/Keyworker Name:

Time Triaged (24Hr) HR | MIN

Referrer: Dr Uman.

Assessor: T Emerson + R. Hinshelwood.

Time Visited HR | MIN

Time Assessment/Contact Completed HR | MIN

Venue Patient See At:

Home ☐ GEMS Clinic ☐ Other ☐ (Please specify):

A&E ☑ Police ☐ Hospital ☐

ARH.

HISTORY

1. Reason for Referral/History of Present Crisis:

Presented with suicidal ideation whilst intoxicated (1 bottle of Buckfast + can of Super Lager).

2. Relevant Psychiatric/Medical History/Present Medication:

PTSD. ongoing difficulties with alcohol
" " " street Diazepam
" " " Cannabis.

3. Mental State Assessment:

Will Include:	Appearance/Behaviour, mood, Suicidal Ideation, Psychotic symptoms, Cognitive functioning, Thought process and insight
May Include:	Sleep, Appetite, Relevant substance abuse, Relevant personal history

STAFF are worried / I am worried about my safety. STAFF contacted Police brought to A+E.
Sexually abused for x 7 years.
Smoke cannabis / valium.
Son Born x 2 weeks ago, not seen him yet.
Livingston ward 17 - for - 2 weeks.
Detox'd however started chasing scan after.
Appt IAT @ 10am, Alcohol Services. 10/9/13.
Claire Duncan - Dykebar hospital - sent home 2 wks ago.
± needs counselling. No mental illness evident.
Reactive - bright. Spent £110 in x 2 days.
Nil psychotic symptoms. alcohol.
Concentration - nil problems reported.
mood OK.
Caught with cannabis £40 the day; Police.
Originally from Livingston.
Cognitively intact at interview.
Nil delusional beliefs voiced / evident.
Enjoy football, Play Station.
Cognitively intact: not formally tested.
Would not have jumped from the window
± looked and thought "Fuck That"!
Can drink x 4 BTLS of Buckfast in a day.
Depressed since my teens - not had anti depressants for years.
± Drink because I'm bored.
I want to go to college + get a trade.
± want to go back to Livingston.
making plans for the future.
Dietary intake sweet.
5 or 6 Bisco a night.

Alcohol dependant
Shake + Sweat in AM.

Has appt with Integrated alcohol Services on 10/9 at 10am ; states he will attend with his brother.

Summary

Problematic alcohol + drug use.

Personality traits???

Had seizure last week. in hospital for x2 days.

Diagnosis:	ICD10 Code:	

Follow Up

1	Client to seek follow up via GP	☑
2	Client to contact Care Team	☑
3	CPN will contact Care Team	☐
4	Psychiatric medical opinion requested	☐
5	Admitted to hospital	☐
6	Urgent CMHT next day follow up	☐

Appropriate referral: Yes ☑ No ☐
(If No, explain):

Signature: J ETHERSON R Mushelwood.

OOHS CPNs

RWA

NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

Affix Label

Hospital (circle)	IRH	RAH	RHSC	GRI	WIG	VI	VIMIU	Stob	VOL	SGH

Royal Alexandra Hospital

CHI: 1203893450

Total Att: **42**

12 Mth Att: **9**

Title: **MR**

WEIR **James**

DOB: **12/03/1989** Age: **24y** Sex: **Male**

12C THRUSHCRAIG CRESCENT
Paisley
Renfrewshire
PA2 6PW
07426895544

Next of kin: **WALKER, Craig**
Relationship: **Brother**
07837 232306

GP: **DC Davidson**
0141 889 5277

Attendance Date: **09/09/2013** Arrival Time: **22:03**

Registration Time: **22:03** Date of Incident: **09/09/2013**

Major Incident Desc:

Reason for Attendance: **personal**

Affix Label

Nursing Assessment

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

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

Presenting Complaint:

Observation Date: **09/09/2013 22:19**

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

Nurse name: **Nurse Kirsty Sandford**

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

GCS:	
Eyes	
Motor	
Verbal	
Total	

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

Nursing Notes:

97607

Child Assessment Questionnaire

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

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

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

DO NOT WRITE HERE PLEASE

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

Date	CLINICAL NOTES
9/9	Seen by (Dr) McMahon CONS EM Time seen see TRAK
	24 o7
	"not coping"
	recent bereavement - mother died
	"not sure what to do"
	biological symptoms - sleep disturbance
	↓appetite
	alcohol xs - 2 bottles buckfast /day
	denies drugs
PMH	alcohol xs
	cirrhosis?
↓ hx	prev offered in pt detox in Livingston
SH	lives alone
	works @ Amazon - off sick due to alcohol
O/E	well
	not intoxicated / withdrawal
	A+B. reasonably dressed
	good eye contact
	↓dgety
	Mood. anxious
	reasonable affect
	T+B. *hallucinations
	Ⓝ thought processes

Date	CLINICAL NOTES
	Suicide - no wish to die no plan wants to feel better Insight - admits alcohol intake harmful wants to stop drinking Suggest: talk ± family GP RV for referral to C.A.T. has details of local A.A samaritans / breathing space etc McMahon

Discharge Codes (Please CIRCLE)									Discharge date	
1. Admission	2. Discharge	3. Refer to GP	4. Transfer to other (see below)							
5. Died	6. Refer to OP Clinic (see below)		7. Irregular Discharge				8. D.O.A.		Discharge time	

Ward number (if admitted):	Transfer to hospital:	Consultant if admitted):

Follow up	Arranged			Not arranged				To be arranged
Clinic referred to	A&E	Hand injury	Fracture	Pop Check	Medical	Surgical	ENT	Others (specify):

Discharge Prescription Packs

Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Frequency	Signature	Given By

Designed by Medical Illustration Services ref 243836

RAH ED Admission Nursing Care Plan

Admission Nurse Signature: _____

Print Name: _____

Patient Label
1203893450 12/03/1989
WEIR
James

Presenting History: Mum recently passed away. Feeling low

Allergies: Penicillin

Date and Time	Progress Notes	Signature

Standard Admission Orders (Please tick when completed)	Tick/ Circle	Optional Admission Orders (Please tick when completed)	Tick	Screening Tools	Tick/ Circle
Infection control issue? If yes, document details above	☐	IV Cannula (if required) dated and timed	☐	SEPSIS risk? SIRS Criteria 2 or more and suspicion of infection	☐
Prepare patient for examination	☐	Blood samples taken	☐	AMT 4 (if > 65 years)	☐
Transfer to Sheet and provide blankets if required	☐	12 Lead ECG	☐	At risk of falls? (clinical judgement) If at risk complete risk assessment	☐
Clothing bagged, labelled and stored under trolley	☐	Cardiac Monitoring	☐	Mental Health Triage Assessment	☐
Nameband attached and allergies identified	☐	E and S BP if indicated	☐	PPURA The patient can reposition themselves whilst in the department?	Y / N
Valuables listed if required and stored appropriately	☐	Peak Flow 1. 2. 3.	☐	There is no reported skin damaged other than presenting trauma?	Y / N
Vital Signs recorded and NEWS score recorded Record on NEWS chart	☐	Urinalysis and Specimen if indicated Results:	☐	The person is fully continent? If NO to any of the above initiate Waterlow risk assessment (within 4 hrs)	Y / N
Pain Score Record on NEWS chart	☐	HCG specimen if indicated +ve " -ve " Strip Lot no:	☐	Waterlow Score If > 10 commence Active Care	☐
Blood sugar level recorded (if required) Record on NEWS chart	☐	Height: Weight:	☐	Active Care Record on Active Care Chart	☐
Communication Aids (spectacles / hearing aid)	☐	Nurse Analgesia	☐	Pressure damage identified on arrival in ED is documented in clinical notes	☐
Interpreter required	Y/N	Child Protection considered (in line with policy)	☐	Grade 3 or 4 Pressure Ulcers are reported on DATIX	☐
Relatives informed	☐	NOK (name and tel no)		Alcohol Brief Intervention FAST/GMAWS completed	☐

	Y	N	NA
Advice leaflets given	☐	☐	☐
Own medications returned	☐	☐	☐
New medications explained	☐	☐	☐
Clothing returned	☐	☐	☐
Valuables returned	☐	☐	☐
Cannula Removed	☐	☐	☐

	Y	N	NA
Out Patient / Clinic Appointment arranged	☐	☐	☐
Relatives Aware of Discharge	☐	☐	☐
Social/ Support Services required and contacted	☐	☐	☐
SAS Transport required and ref no.	☐	☐	☐
Other means of transport arranged by nurse	☐	☐	☐
Signature (of nurse discharging patient)			

Emergency Department - Active Care

I have evaluated and deemed that the frequency of care delivery over the next work shift, based on the patient's most critical need should be every:

(Please circle) ½ hour 1hour 2 hours

Signed ..... Name .....

Patient Addressograph Label

			Time							
	1.	PAIN: Assess and address If in pain inform registered nurse Y or N/A								
S	2.	SKIN INSPECTION A. Pressure areas checked:								
		B. Redness (R) / Discolouration (D) / Pressure Ulcer (PU)								
K	3.	KEEP MOVING: A. Have you moved or walked Y / N / I (independent)								
		B. Trolley Right side (30° tilt) – R Left Side (30° tilt) – L Back– B								
		C. Chair Assist to walk, stand or tilt (W /ST/ T)								
I	4.	ELIMINATION: Do you need the toilet? I = Independent A = Assistance given IC = patient incontinent of urine/faeces								
N	5.	FOOD, FLUIDS AND NUTRITION: Is the patient nil by mouth? Y / N (consider mouth care)								
		Encourage the patient to drink? (if appropriate) Y / N / N/A								
		Food, snack or supplement taken? (if appropriate) Y / N / N/A								
	6.	ENVIRONMENT: Is the patient able to call for assistance? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the trolley in lowest position?								
	7.	INFORMATION: Ask: Is there anything else I can help you with? Inform patient of the time of return.								
	8.	ESCALATION: Escalate any issues to the Registered Nurse / Dr Y / N/A								
		Nurse Initials								

USE FOLLOWING CODE	Specialist Pressure Redistributing equipment	Variations			
V = Variant I = Independent NT = No thanks	☐ Repose Mattress ☐ Moving and handling aids ☐ Other:	Time	No.	Variation	Signed

Waterlow Pressure Area Risk Assessment

Build/Weight		Skin Type/Visual Risk Areas		Sex/Age		Special Risks -Tissue Malnutrition	
Average (BMI 20-24.9)	0	Healthy	0	Male	1	Multiple organ failure/ Terminal cachexia	8
Above Average (BMI 25-29.9)	1	Tissue Paper (thin/fragile)	1	Female	2		
Obese (BMI > 30)	2	Dry (appears flaky)	1	14-49	1	Single organ failure	5
Below Average (BMI < 20)	3	Oedematous (puffy)	1	50-64	2	Peripheral Vascular Disease	5
Continence		Clammy /pyrexia	1	65-74	3	Anaemia = Hb < 8	2
Complete/Catheterised	0	Discoloured (brusing/mottled)	2	75-80	4	Smoking	1
Incontinent urine	1			81+	5	Neurological Deficit	
Incontinent faeces	2	Broken (established ulcer)	3	Nutritional Element		Diabetes/MS/CVA Motor or sensory paraplegia (Max 6)	4-6
Doubly Incontinent (urine and faeces)	3	Mobility		Unplanned weight loss in past 3-6 months < 5% Score 0 5-10% Score 1 > 10% Score 2			
		Fully mobile	0				
Special Risks – Surgery/Trauma		Restless/Fidgety	1			Special Risks - Medication	
On table > 6 hours	8	Apathetic (sedated/depressed/ reluctant to move)	2			Cytotoxic, anti-inflammatory, long term/high dose steroids (Max 4)	4
Orthopaedic / below waist/Spinal (up to 48 hrs post-op)	5			BMI > 20 Score 0 BMI 18.5-20 Score 1 BMI < 18.5 Score 2		Risk Score 10+ = 'At risk' 15+ = 'High Risk' 20+ = 'Very High Risk'	
On table > 2 hours (up to 48 hrs post op)	5	Bed bound (unconscious/unable to change position/traction)	4				
		Chair Bound	5	Patient acutely ill or no nutritional intake > 5 days	2		

Patient's Initial Waterlow Score = If Score ≥10 Complete the Adapted Waterlow Pressure Area Risk Assessment Chart

Emergency Department
Mental Health Triage and Risk Assessment

NHS Greater Glasgow and Clyde

1203893450 12/03/1989
WEIR
James

Emergency Department Triage
This side to be completed by triage nurse.

Patient Name _____

DoB _____ CHI _____

Triage Observations
Document physiological measurements

GCS	BM	HR	BP	RR	SaO_2	Temp
15		92	120/70	17	98	36.3

Accompanied by...
Name, relationship, particular concerns

alone

Or describe the patient's physical appearance/clothing if attending alone as they may leave before assessment

Is the patient a young person in foster care or in a residential care placement? Yes/No

Is the patient a carer for a child or for a dependent adult? Yes/No

Is there a child protection concern or concern for an adult at risk? Yes/No

Outline of Presentation
Tick all those categories which apply and provide a brief summary

Overdose – will require medical assessment		recent bereavement - low
Self-Injury - will require wound management		
Other Mental Health Presentation	X	

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

Is the patient violent, aggressive or threatening?	Yes		(No)
Is the patient obviously distressed, markedly anxious or highly aroused?		(Yes)	No
Is the patient quiet and withdrawn?		(Yes)	No
Do you think the patient is behaving inappropriately to their situation?		Yes	(No)
Do you think the patient presents an immediate risk to you, to others, or to themselves?	Yes		(No)
Do you think the patient is likely to abscond prior to assessment?	Yes		(No)
Do you think the patient's presentation suggests either delusions or hallucinations?*	Yes		(No)
Do you think the patient's presentation suggests they feel their actions are being controlled?	Yes		(No)
Are you aware of a history of mental health problems or psychiatric illness?		Yes	(No)
Are you aware of a history of violence or self harm?		Yes	(No)
Is the patient currently expressing suicidal thoughts	Yes		(No)

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

Triage Risk Assessment
Indicate an initial category of risk by circling one and selecting one or more risks

High/Moderate/Low Risk
of self-harm/violence/absconding in department

Triage Category	2	high risk – supervised *and* in the department moderate risk – supervised *or* in the department low risk – can be asked to wait if necessary

Any responses in the first column
High Risk

Other patients can be categorized as
Moderate Risk

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

Immediate Management
Print toxbase information, and in paracetamol overdose, document 4 hour time for sample

Patient location, supervised by...			
Blood sample time?		Toxbase Information Printed?	

Print Name [illegible]

Signature _____

Date 9/9/13 Time 2220

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Emergency Department Mental Health Assessment

This side to be completed by medical staff

Outline of current presentation and precipitating factors

Previous mental health problems, self harm, addictions, medication etc

Other relevant information; relationships, finances, employment, housing, physical health, childcare etc

Appearance	Behaviour	Speech
Mood	Thought	Insight

Risk Assessment

Based on clinical assessment, indicate a category of risk of a further episode of self-harm in the short term – 48 hrs - considering any protective as well as precipitating factors

High/Moderate/Low

Summary and Plan for Further Assessment

Referral to liaison psychiatry, duty doctor, CPN service, CMHT, GP, addiction services, SW, etc

Summary

Service Referred to	Time of Referral

Discharge

Indicate the follow-up plan, advice given, and identities of others informed of the decision

Follow up and advice	Carer informed

Name and Designation of Consultant or Middle-Grade Involved in Reviewing Patient	

Risk Factors (yes/no/unknown)

male gender	y	n	u
age >18 and <65	y	n	u
depression	y	n	u
alcohol or drug use	y	n	u
separated, widowed, divorced	y	n	u
suicide plan/concealment	y	n	u
evidence of psychosis	y	n	u
ongoing suicial intent	y	n	u
lack of social support	y	n	u
chronic physical illness/pain	y	n	u
family history of suicide	y	n	u
family concerned about risk	y	n	u
disengaged/poor compliance	y	n	u
unemployed or retired	y	n	u
access to lethal means of harm	y	n	u
previous violent methods	y	n	u
history of self harm/overdose	y	n	u
previous psychiatric treatment	y	n	u
current psychiatric treatment	y	n	u
current use of benzodiazepines	y	n	u

If young people in foster or residential care are assessed, their social work team should be informed, (via standby SW if out-of-hours), *and* correspondence given to carers present.

Print Name _____

Signature _____

Date & Time _____

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version 2.0 – February 2013

NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

Name
Address

1203893450 12/03/1989
WEIR
James

CHI No.
DoB

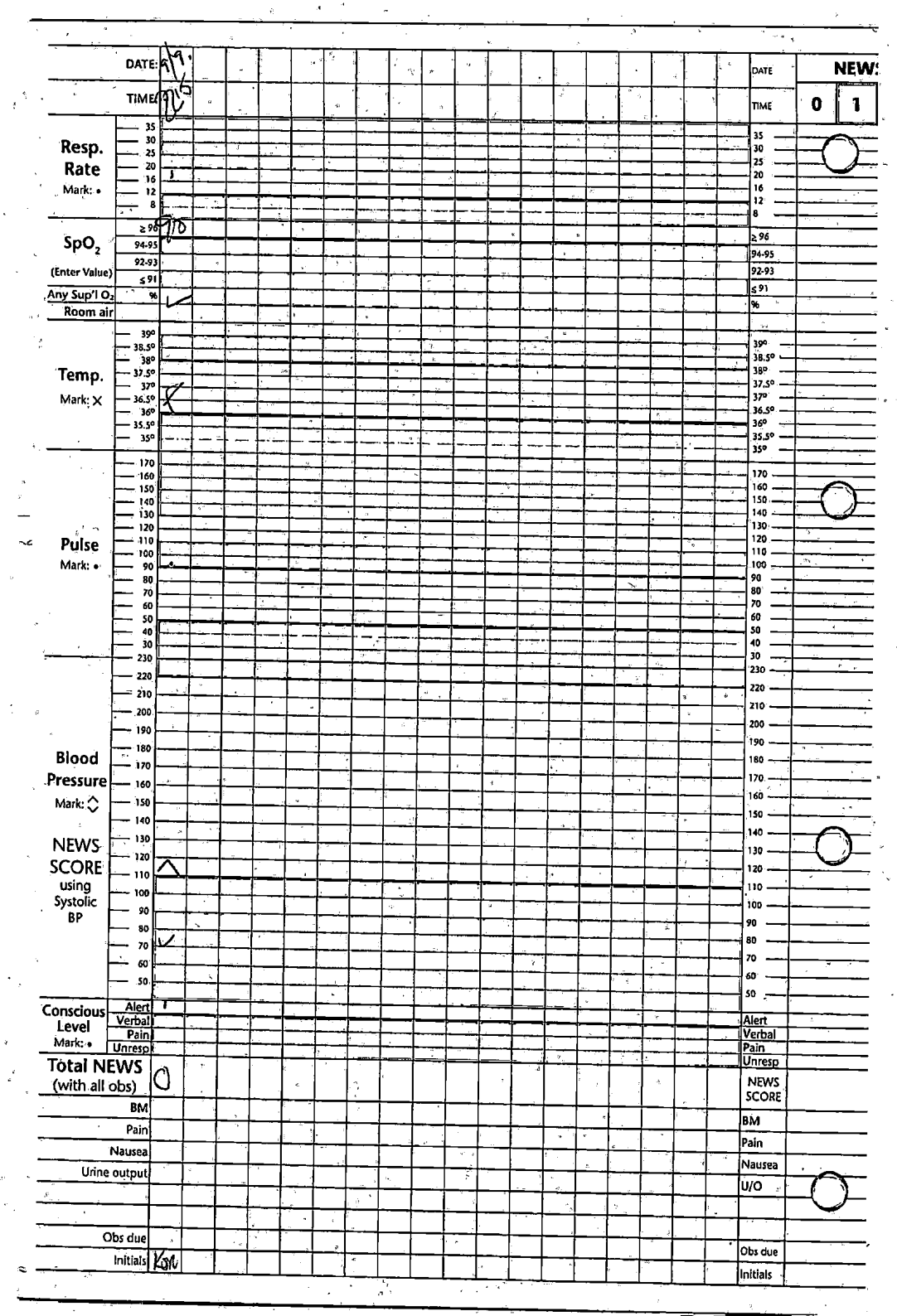
	Date	Ward
Admitted	9/9/13	CV
Transferred		
Transferred		

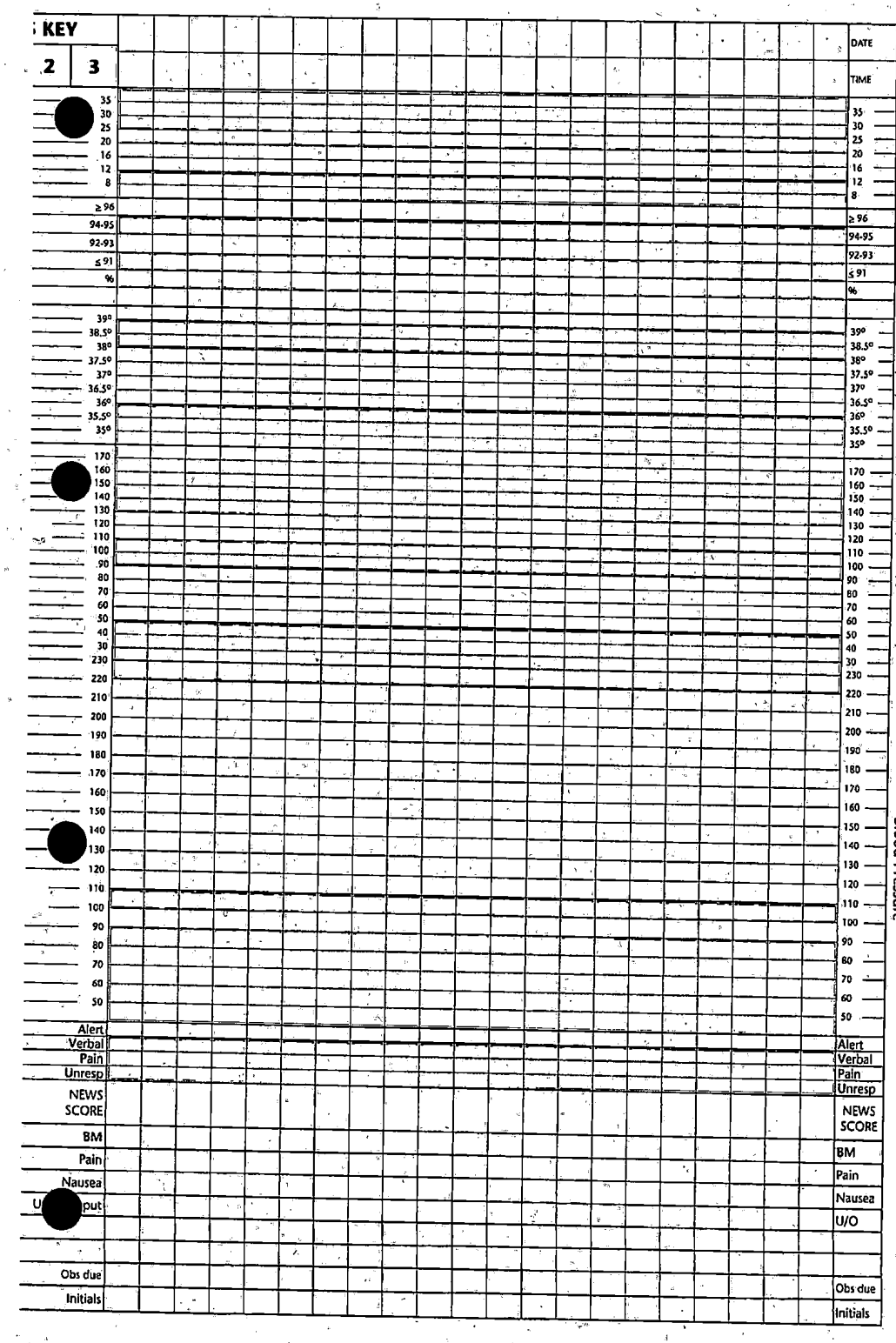
Physiological Parameter	NEWS – NHS Early Warning Score						
	3	2	1	0	1	2	3
Respiration Rate	≤8		9-11	12-20		21-24	≥25
Oxygen Saturations	≤91	92-93	94-95	≥96			
Any Supplemental Oxygen		Yes		No			
Temperature	≤35.0°		35.1-36.0°	36.1-38.0°	38.1-39°	≥39.1°	
Pulse	≤40		41-50	51-90	91-110	111-130	≥131
Systolic BP	≤90	91-100	101-110	111-219			≥220
Conscious Level				A			V, P or U

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

See NEWS Actions Reference Tool for local escalation policy

NEWS Score	Frequency of Monitoring	Clinical Response
0	Minimum 12 hourly	• Continue routine NEWS monitoring with every set of observations.
Aggregate 1- 4	Minimum 4 hourly	• Inform trained nurse. • Trained Nurse assessment: - Assess the patient - Review frequency of monitoring required - Assess need for escalation of clinical care and direct as appropriate.
Aggregate 5 or more **or** 3 in one parameter	Increased frequency to a minimum of 1 hourly	• Trained Nurse assessment. • Inform medical team caring for the patient. • Urgent assessment by a medical / surgical / nursing team with core competencies to assess acutely ill patients. • Consider level of monitoring required in relation to clinical care.
Aggregate 7 or more	Continuous monitoring of vital signs	• Trained Nurse to assess immediately. • Inform medical team caring for the patient – this should be at least senior medical staff level. • Emergency assessment by a clinical team with core competencies in the assessment of critically ill patients. This team will have critical care competencies and a practitioner/s with advanced airway skills and resuscitation skills. • Consider referral to high dependency or ITU.


DATE
TIME
NEWS
0
1
Resp. Rate
Mark: •
SpO2
(Enter Value)
Any Sup'l O2
Room air
Temp.
Mark: X
Pulse
Mark: •
Blood Pressure
Mark:
NEWS SCORE using Systolic BP
Conscious Level
Mark: •
Alert
Verbal
Pain
Unresp
Total NEWS (with all obs)
BM
Pain
Nausea
Urine output
Obs due
Initials
NEWS SCORE
U/O


KEY
2
3
DATE
TIME
Resp. Rate
35
30
25
20
16
12
8
SpO2
≥ 96
94-95
92-93
≤ 91
%
Temp.
39°
38.5°
38°
37.5°
37°
36.5°
36°
35.5°
35°
Pulse
170
160
150
140
130
120
110
100
90
80
70
60
50
40
30
Blood Pressure
230
220
210
200
190
180
170
160
150
140
130
120
110
100
90
80
70
60
50
Alert
Verbal
Pain
Unresp
NEWS SCORE
BM
Pain
Nausea
U/O
Obs due
Initials

Neurological Observations

| | | |

MW (6)

NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

Affix Label

CHI: 1203893450

Royal Alexandra Hospital

Total Att: 79

12 Mth Att: 0

Title: MR

WEIR James

DOB 12/03/1989 Age: 31y Sex: Male

27D MACDOWALL STREET

Johnstone
Renfrewshire
PA5 8QJ
07572 333 730

Next of kin: WEIR, Deborah
Relationship: Sister
~~0[illegible]~~
07306 306678
GP: JC Sim
01505 321733

Attendance Date: 10/06/2020 Arrival Time: 15:12

Registration Time: 15:12 Date of Incident: 10/06/2020

Major Incident Desc:

Reason for Attendance: alcohol withdrawal

Affix Label

Nursing Assessment

Alerts: Not Recorded Allergies: Yes Pain Score:

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

Presenting Complaint:

Observation Date: 10/06/2020 15:19 Nurse name: Nurse Laura Bruce

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

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

GCS	
Eyes	
Motor	
Verbal	
Total	

Pupils-Right		Pupils-Left	
Size (mm)		Size (mm)	
Reaction		Reaction	

Nursing Notes: Alcohol withdrawl. hx alcohol excess, stopped drinking 2/7 ago, vomiting, tremulous

Child Assessment Questionnaire

	YES	NO
Previous attendance (consider any relevant trauma from previous presentations)		
History variable between accounts		
Examination not compatible with history/presentation		
Delay in presentation		
Fracture/head injury or significant bruising in baby or non-mobile toddler		

Discuss with Senior Medical Staff / Nurse on duty any factors identified

X-Ray and Other Reports to be filed on this side (if the patient is not being admitted)

DO NOT WRITE HERE PLEASE

ONCE ONLY PRESCRIPTIONS (including Tetanus Prophylaxis)						
Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Time of Administration	Signature	Given By
10/06	PABRINEX	2x2vial	IV	16.55		WO.

Date	CLINICAL NOTES
	Seen by (Dr) Time seen

See medical admission booklet.

Date	CLINICAL NOTES

Discharge Codes (Please CIRCLE)						Discharge date	
1. Admission	2. Discharge	3. Refer to GP	4. Transfer to other (see below)				
5. Died	6. Refer to OP Clinic (see below)		7. Irregular Discharge	8. D.O.A.		Discharge time	

Ward number (if admitted):	Transfer to hospital:	Consultant If admitted):

Follow up	Arranged			Not arranged			To be arranged	
Clinic referred to	A&E	Hand injury	Fracture	Pop Check	Medical	Surgical	ENT	Others (specify):

Discharge Prescription Packs

Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Frequency	Signature	Given By

Immediate Discharge Letter

NHS Greater Glasgow and Clyde

Highly Sensitive: No
Consent for Sharing Withheld: No

JULIET SIMQuarryside Medical Practice,Linden Medical Centre,25 Floors Street, Johnstone, PA5 8PZ

Royal Alexandra Hospital,Corsebar Road,Paisley,PA2 9PN
Main Switchboard: 0141 8879111
Date of Completion: 13-Jun-2020

Dear JULIET SIM;

Name	CHI	DoB	Address
James Weir	1203893450	12-Mar-1989	27D MACDOWALL STREET, Johnstone, Renfrewshire, PA5 8QJ

Admitted	Type	Discharged	Destination
10-Jun-2020 18:47	IP	11-Jun-2020	

Specialty	Consultant	Ward	Telephone
General Medicine	Gravil	RAH AMU Ward 2 General Medicine	0141 8879111

Primary Diagnosis
There is no data to display.

Secondary Diagnosis
There is no data to display.

Significant Operations / Procedures:
There is no data to display.

Last Discharge Review: Mairi Laing (Mairi Laing - FY1) on 13 Jun 2020 13:14

Discharge Medication:

Active Drug Name	Route	Dose	Disp	Reason	Further Details	ECS	Since Admission
Mirtazapine 15mg tablets	oral	ONE TO BE TAKEN AT NIGHT,	No	Patient left before supplied		Y	

"Added" means this medicine was added to the Clinical Portal record after admission. It does not necessarily mean this medicine was started by the hospital.

Dispensing Comments
There is no data to display.

Withheld Medication:

Date	Withheld Drug Name	Route	Dose	Note	Withheld Reason
There is no data to display.					

Stopped Medication:

Date	Stopped Drug Name	Route	Dose	Note	Stopped Reason
There is no data to display.					

Reason for Admission and Presenting Complaints	Admission Category
No data available	No data available

Clinical Comments:

Dear doctor,

Mr Weir was admitted to the RAH on 10/06/20 in alcohol withdrawal with a history of vomiting after stopping drinking 1 day previous. He also described some haematemesis. Haemoglobin was 146.

Impression: Alcohol withdrawal

Mr Weir was admitted for GMAWS, Pabrinex and IV fluids.

Mr Weir wished to discharge against medical advice and left the ward.

No change to regular medications.

	Kind regards, Mairi Laing FY1 AMU
Follow Up:	No
Results Awaited:	No
Pharmacist Comments:	
Final Discharge Letter to Follow:	Yes

Yours sincerely,

Mairi Laing

Prescription Review
Checked by: Mairi Laing (FY1)
Discharged by: Mairi Laing (FY1)

Cycle 20

NHS
Greater Glasgow and Clyde

Acute Medical Unit Admission Proforma

MAU/A&E/AMU

Royal Alexandra Hospital, Paisley/Vale of Leven Hospital/IRH

Patient Details		
Name: **Address:**	1203893450 WEIR M James 12/03/1989 27D MACDOWALL STREET Johnstone, Renfrewshire PA5 8C	**Sex:** F ☐ M ☑ **DoB** 12/03/89 **Age:** 31
Telephone:	07572338730	
GP:	Dr. JC Sim Quarryside Medical Practice Linden Medical Centre 25 Floors Street Johnstone PA5 8PZ	
Next of Kin:		
Telephone:		

Episode Details			
Date patient seen:	10/06/2020	**Time seen:**	1700
Source of referral:	GP ☐ A&E ☑ OPD ☐ Self ☐ Other =		
Admitting Dr:	BOGUE	**Grade** FY2	**Bleep**
Consultant:	MacDonald		

Resuscitation Decision

Resuscitation status: (please circle) **FOR RESUSCITATION** / **DNA CPR**

Signature: _____ **Name:** BOGUE **Grade:** FY2

If DNA CPR → Complete appropriate form

Cycle 20

Presenting Complaint(s)	
Presenting complaint	Alcohol withdrawal /? UGI bleed
History of presenting complaint	Stopped drinking yesterday 1pm - became anxious, tremulous since - ? seizure last night - unwitnessed This morning had 1 bottle of wine with advice of ? ward ? mental health team to abate withdrawal symptoms Vomited several times - green/yellow stained contents followed by several episodes of haematemesis - fresh red blood Also describes 2 week history black, tarry stools c/o ? melaena No plans to continue drinking - determined to stop + wants to be mental health nurse Attributes drinking to sexual abuse - made worse by seeing his abuser daily in street. Currently scoring on CIWA-Ar due to agitation, tremor, tachycardia States has ongoing suicidal ideation. Has made plans which he doesn't want to discuss. What has stopped him is support from sister + niece + also knowledge of own recovery potential No drug use other than occasionally smoking cannabis Usually 20-30 units/day - wine/Buckfast/cider

Past Medical History / Review of Old Notes. Review eKIS if available
Emotionally unstable personality disorder

Systemic Enquiry
Some dysuria described

Cycle 20

MEDICINES RECONCILIATION – Acceptable to staple fully completed Emed Rec

Source of medication history . . Patient ☐ Relative/carer ☐ GP Phone call ☐ ECS ☐

(>1 source preferred) Patient own drugs ☐ Com. Pharmacist ☐ GP letter/summary ☐ Repeat Script ☐

Other (please specify) .....

Admission Medicines	Dose	Frequency	Plan for medicines (Dr complete) Continue / Amend Withold Stop	Comments Reason for alteration
Pravastatin	15mg	OD		

Staple emed-rec to this page

Allergies	List any over-the-counter or alternative medicines
None known ☐ Penicillin	
	Do medicines need further clarification ? Yes ☐ No ☐
List collected by :	Plan approved by :
Designation : Date :	Designation : Date :

Pharmacy review	Comments	
Compliance aid : Yes ☐ No ☐	Community pharmacist	Phone
Reviewed by :	Designation :	Date :

Cycle 20

Social History

Smoking History

Ex-smoker/Smoker ____cpd ___yrs Never smoked

Alcohol History

Z10 Units/week FAST score if excess 16

Recreational Drugs Driving Status

Cannabis

Social Circumstances (home, supports, functional status, occupation, travel)

Lives alone. Functionally independent
Sister close by - parents moderate dementia

Family History

Observations

RR: 17 bpm Sats: 97% FiO2: RA Temp: 36.5 °C BP 125/80 HR 90-100 bpm BM: 5.6

General Examination

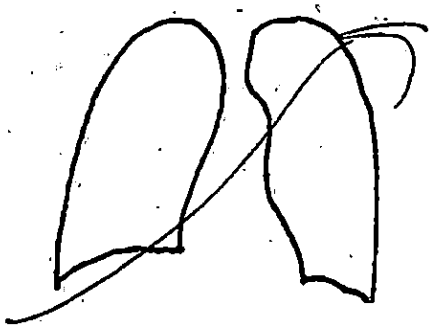
General Appearance:

Tearful, agitated
Sitting comfortably

Cyanosis / pallor / jaundice / clubbing / lymphadenopathy

Respiratory

PEFR =



Cycle 20

Cardiovascular

Pulse **Heart Sounds** 1+1+0

JVP ↔

Oedema No

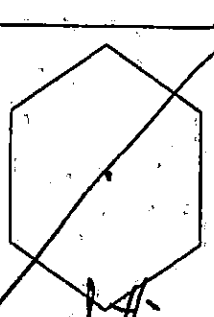
Peripheral Pulses ✓ **cap refill** <2

Gastrointestinal system

Masses: ✗

Organomegaly: ✗

Bowel sounds: ✓



PR: Patient declined – concerned this will bring up memories of historic sexual abuse

Neurological system

GCS: 14/15 **E:** 4/4 **M:** 6/6 **V:** 4/5 **AMT:** 7/4 (AMT 4 = age, time, place, year)

Pupils/fundoscopy: PEARL

Cerebellar and extrapyramidal:

Cranial Nerves: moving all four limbs

Neck:

	RUL	LUL	RLL	LLL
Tone				
Power				
Co-ordination				
Reflexes				
Sensation				

Gait:

Locomotor

	Tender	Swollen	Deformity	Which joint?
Arms				
Legs				
Spine				

Cycle 20

Investigations

- Bloods.

(Differential) diagnosis

Alcohol withdrawal

? UGI bleed
- Glasgo-Blatchford score
→ 0 but anxiety
was ✓

Management Plan

- Admit medicine
- Z-Z pabrinex
- GMAWS

Thromboprophylaxis assessed ☐ **Medicine Reconciliation** ☐ **DD6 if required** ☐

Signature [signature] **PRINT NAME** ROSS BOGUE **Page:**
PRINT GRADE FY2

Senior/Medical review

Dr Marks

Pt highly emotional + visibly highly anxious + tearful stating in pain ++ and wishes for us to contact sister lengthy talk regarding issues + while pt clearly wants + would benefit from ψ input @ same step main issue is alcohol withdrawal + distress @ being in hospital

Plan + Further 20mg diazepam
- Analgesia
- Anti-emetic
- Attempt to contact sister (number on ED card)
- IV fluid (visibly dry)

[signature]

Admission checklist

Investigations reviewed ☑ **Kardex** ☒ **eKIS reviewed** ☒
Thromboprophylaxis assessed ☑ **Medicine Reconciliation** ☐ **DD6 if required** ☐

NHS GG&C Adult Risk Assessment for Venous Thromboembolism (VTE)

[excluding orthopaedics, obstetrics and gynaecology & ENT who have specialty-specific policies]

- Risk Assessment must be completed for all patients within 24 hours of admission to hospital
- Patients must be reassessed every 48-72 hours or sooner if condition changes
- Reassessment must be documented in Kardex
- Please complete risk assessment and then sign and date Risk Assessment Result box at bottom of page.

Pt Addressograph

Surgical patients start here

Non-operative [mainly medical] patients start here

Is the patient bed-bound or expected to have reduced mobility relative to normal state for ≥ 2 days?

Yes ☐ No ☐

Does the patient have any risk factors for thrombosis? (tick √ all that apply)

Age >60	☐	Use of oestrogen-containing contraceptive therapy	☐
Active cancer or cancer treatment	☐	Use of hormone replacement therapy	☐
Dehydration	☐	Pregnancy or < 6 weeks post partum (seek specialist advice)	☐
Known thrombophilias	☐	Critical care admission eg HDU/ITU	☐
Obesity (BMI>30)	☐	Total anaesthetic + surgical time >90 minutes	☐
Current significant medical condition e.g. Serious infection, Heart failure, Respiratory disease or inflammatory disease	☐	Surgery involving pelvis or lower limb with a total anaesthetic + surgical time >60 minutes	☐
Personal history or first degree relative with a history of VTE	☐	Acute surgical admission with inflammatory or intra-abdominal condition	☐
Varicose veins with phlebitis	☐	Hip fracture	☐

- No thromboprophylaxis required.
- Continue to reassess every 48-72 hours or sooner if condition changes.
- Document all reassessments in drug kardex.
- Risk assessment now complete
- Complete Risk Assessment Result Box

Yes, 1 or more risk factors identified ☐

No risk factors identified ☐

Does the patient have any contraindications to pharmacological prophylaxis? (tick √ all that apply)

Active bleeding	☐	Untreated inherited bleeding disorders (e.g. haemophilia or von Willebrands)	☐
Acquired bleeding disorders (e.g. acute liver failure)	☐	Neurosurgery, spinal or posterior eye surgery	☐
Concurrent use of anticoagulants (such as warfarin with INR>2)	☐	Lumbar puncture, epidural/spinal anaesthesia expected within the next 12 hours	☐
Acute stroke	☐	Other procedure with high bleeding risk – discuss with senior if unsure	☐
Uncontrolled hypertension (230/120 mmHg or higher)	☐	Lumbar puncture, epidural/spinal analgesia within the previous 4 hours	☐
Thrombocytopenia (<75 x 10⁹/l)	☐	Thyroid surgery	☐

- Discuss with senior clinical staff before prescribing pharmacological prophylaxis
- Consider mechanical prophylaxis e.g. AES unless contra-indicated.
- Reassess patient every 48-72 hours or sooner if condition changes

No contraindications to pharmacological prophylaxis identified ☐

Contraindications to pharmacological prophylaxis identified ☐

Surgical patients – Enoxaparin 40mg + AES ☐*

*prior to application of AES, please check contraindications to AES

Medical patients – Enoxaparin 40mg ☐

Prescribe Enoxaparin at 6pm
[on day of surgery, at the later of either 4h post-op or 6pm]

Reduce Enoxaparin to 20mg if <50Kg or eGFR <30ml/minute/1.73m² ☐

Discontinue at discharge or when returned to pre-morbid mobility

Contraindications to anti-embolism stockings (AES) Y ☐ N ☐

Peripheral neuropathy	☐
Peripheral vascular disease	☐
Cellulitis or Gross oedema	☐
Leg deformity or Fragile skin	☐
Leg / foot ulcers	☐
Allergy	☐
Unusual leg size/shape	☐

Risk assessment result – please tick √ all that apply

VTE risk factors: YES ☐ NO ☐ Contraindications to pharmacological prophylaxis: YES ☐ NO ☐ Prescribed: LMWH ☐ AES ☐ NONE ☐

Patient informed of VTE risks and benefits of thromboprophylaxis YES ☐ NO ☐ N/A ☐ Information leaflet provided YES ☐ NO ☐

Print Assessor's Name: _____ Signature: _____ Date: _____

RAT Medicine & Surgery 16/01/2014 – TEST OF CHANGE 08

MIS 250744-2

DD6 **All patients over 64**

4AT	Y/N/Na
Carers involved	Y/N/Na
Med rec	Y/N/Na
Sepsis Screen	Y/N/Na
Resuscitation status considered	Y/N
Discharge planning	Y/N/Na

Sepsis Six

Antibiotics within 1 hour	☐
Appropriate Cultures	☐
Fluids	☐
Oxygen	☐
Lactate	☐
Fluid balance, consider catheter	☐

Cycle 20

Results

Baseline										
	Date									
	Time									
	Parameter	Ref Range								
	Hb	130-180	146							
	WCC	4.0-11.0								
	Plts	150-400								
	MCV	78 - 99								
	Neut	2.0 - 7.5								
	PT	9.0 - 13.0								
	APTT	27.0 - 38.0								
	Fibrinogen	1.5-4gm/L								
	INR	( )								
	Thromb T	11-15 secs								
	D-Dimer	<230								
	ABG/VBG									
	Na^+	135 - 145								
	K^+	3.5 - 5.0								
	Cl^-	97 - 107								
	HCO_3^-	23 - 30								
	Urea	2.5 - 7.5								
	Creat	62 - 124								
	eGFR									
	Glucose	3.5 - 5.9								
	Protein	32 - 82								
	Albumin	37 - 50								
	AlkP	33 - 117								
	Bil	0.5 - 19								
	ALT	11 - 55								
	AST	13 - 42								
	GGT	8-60								
	ESR									
	CRP	<3								
	Troponin I hs	Men 0 - 34 Women 0 - 16								
	CK	23 - 190								
	Corr Ca^{++}	2.25 - 2.60								
	PO_4^-	0.8 - 1.4								
	Mg^{++}	0.7 - 1.1								
	Digoxin	0.5 – 2.0								
	Alcohol									
	Paracetamol	<100 @4 hr								
	Salicylate									
	Amylase	<100								
	LDH	240 - 480								
	Folate	3.1 - 20								
	B12	200 - 900								
	Ferritin	15 - 200								
	TSH	0.35 – 5.00								
	T4	9 - 21								
	Urinalysis									

DON'T MISS AKI Checklist within 24 hrs of admission

D Dipstick Urine: _____

O Obtain Ultrasound: Yes ☐ N/A ☐

(Stage 2/3: within 24 hours of Admission)

N Need for Catheter: Long-term ☐ Yes ☐ No ☐ Refused ☐

T Team Renal to contact: Considered ☐ Done ☐ N/A ☐

M Medicine Reconciliation: ☐

I Intravenous Fluids: Yes ☐ Contraindicated ☐

S Suspected Cause: _____

S Staging of AKI: (Tick Box Below)

☐ 1 (RISK if: Creatinine X 1.5)
☐ 2 (INJURY if: Creatinine X 2)
☐ 3 (FAILURE if: Creatinine X 3)
(compared to baseline)

Signature/Name/Grade _____

Cycle 20

Post Take Ward Round AMU/MAU/OAAU

Consultant: CRANN **Date:** 2 10/6/20 **Time:** 8.15p-

Summary 83y/ Alcohol + Mental Health issues
Trial to stop drinking.
Vomiting + fever 3/7
? bone blood in vomit.
CXR requested awaiting report
Possibly Load a Pyrexia (test myself)
Person should referred Psych

O/E well-
Jaundiced
Tremulous.

Temp:
Pulse:
BP:
Sat O2:
FiO2:
RR:

ECG:

Bloods: (N) 145 146

CXR: Not done

Other investigations:

Imp: Alc withdrawal

Plan: Pabrinsky not Pyrexia blood
CIWA-Ar Fixed Dose
Pabrinsky
Alc home

AWI considered ☐ Thromboprophylaxis need reviewed ☐ Medicine reconciliation complete ☐
If cardiac or respiratory arrest is considered a possibility for the patient has CPR status been reviewed and documented Yes ☐ No ☐
CPR decision discussed with patient Yes ☐ No (document why) ☐ Advanced directive in situ ☐ Treatment escalation plan (circle) Ward/HDU/ITU
Family informed of CPR/escalation status? – Needs discussed at first opportunity ☐ Has been discussed ☐ Patient does not want family informed ☐

Recommended Destination: Any Ward
Suitable to board if required Yes ☐ No ☐
Expected Date of Discharge: _____

Signature: _____
Designation: _____
Bleep Number: _____

Cycle 20

Junior/Senior additional notes, communications with relatives

Weir James CHI: 1203893450

Immediate Discharge Letter

Highly Sensitive: No Consent for Sharing Withheld: No

NHS
Greater Glasgow and Clyde

Royal Alexandra Hospital
Corsebar Road
Paisley
PA2 9PN
Main Switchboard: 0141-887-9111
Date of Completion: 11/08/2015

Dr. EC Renwick
Quarryside Practice
Linden Medical Centre
25 Floors Street
Johnstone
PA5 8PZ

Dear Dr EC Renwick,

Name	CHI	DoB	Address
James Weir	1203893450	12/03/1989	27D MACDOWALL STREET Johnstone PA5 8QJ

Admitted	Type	Discharged	Destination
11/08/2015 02:16	In Patient	11/08/2015	

Specialty	Consultant	Ward	Telephone
General Medicine	Dr Zia Mustafa Mohammed	RAH AMU Ward 2 General Medicine	0141-314-9756/9763

Reason for Admission and Presenting Complaints	Admission Category
	Admission for treatment - Where the patient is expected to be treated for a diagnosed condition not otherwise specified

Diagnosis	Site	Side
Acute Alcohol intoxication (ICD10: F10.0)		

Date	Procedures/Interventions/Operations

Clinical Comments: Dear Doctor,

This 26 year old man presented to A and E with a witnessed collpase and possible pseudoseizure. There was no head injury, seizure activity, tongue biting or urinary incontinence. He subsequently had an episode of unresponsiveness with GCS of 3, though this was short-lived.

Mr Weir remembered being with a friend to celebrate a new job over breakfast. He thought that the friend 'gave him something' and the next thing he remembered, he was in resus and feeling unwell.

He had a further collapse in the corridor. He was unrousable and had soe psuedoseizure activity. Afterwards he did not engage nd his GCS was 15/15 with the ijmpression that this was due to alcohol intoxicaton. On 11th

-August he had left the hospital. He did not express suicidal ideation but police were contacted and they will search for him. On discharge, he had two IV cannulae. He had been referred to alcohol addictions and will check if he will have any community psychiatric input.

Kind regards,
Sukhmeet Singh (FY1)

Treatments: None recorded.

Follow-up arranged: Currenly being searched for by police.

Planned Outpatient Investigations: nil

Final Discharge letter to follow: Yes

Medication Info:

Allergies: Penicillins

Height: cm **Weight:** kg

Discharge Medication:

Medicine	Route	Dose	UOM	Frequency	Duration	Pharmacy Comment
Omeprazole Capsules	Oral	20	mg	ONCE a Day	No duration defined.	
Venlafaxine Tablets	Oral	75	mg	ONCE a Day	No duration defined	

Discontinued Medication:

Drug Name	Dose	UOM	Reason

Yours sincerely,
Dr Sukhmeet Singh
Doctor

Prescription Review
Medications Reviewed by Pharmacist: ,
Dispensed Medications Checked by Pharmacy: ,
Nurse discharging patient: Teresa Porter,

NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

CHI: 1203893450

Royal Alexandra Hospital

Total Att: 65

12 Mth Att: 9

Title: MR

WEIR James

DOB: 12/03/1989 Age: 26y Sex: Male

27D MACDOWALL STREET
Johnstone
Renfrewshire
PA5 8QJ
07474837113

Next of kin: WEIR, Deborah
Relationship: Sister
0758859964

GP: EC Renwick
01505 321733

Attendance Date: 10/08/2015 Arrival Time: 19:24

Registration Time: 19:24 Date of Incident: 10/08/2015

Major Incident Desc:

Reason for Attendance: chest pain

Affix Label

Nursing Assessment

Alerts: Not Recorded Allergies: Yes Pain Score:

Triage Category: 1 Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: 10/08/2015 20:22

Temp		C
HR		bpm
BP	/	mmHg
MAP		mmHg
RR		bpm
SpO2		%
Oxygen		%

Nurse name: Nurse Laura Bruce

BM		mmol/L
PF		l/min
Expected PF		l/min
Weight		kg
Height		cm
Visual Acuity		
Left		
Right		
Corrected?		

GCS	
Eyes	
Motor	
Verbal	
Total	

Pupils-Right		Pupils-Left	
Size (mm)		Size (mm)	
Reaction		Reaction	

Nursing Notes:

Child Assessment Questionnaire

	YES	NO
Previous attendance (consider any relevant trauma from previous presentations)		
History variable between accounts		
Examination not compatible with history/presentation		
Delay in presentation		
Fracture/head injury or significant bruising in baby or non-mobile toddler		

Discuss with Senior Medical Staff / Nurse on duty any factors identified

X-Ray and Other Reports to be filed on this side (if the patient is not being admitted)

DO NOT WRITE HERE PLEASE

ONCE ONLY PRESCRIPTIONS (including Tetanus Prophylaxis)						
Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Time of Administration	Signature	Given By

Date	CLINICAL NOTES

Inj: collapse ? cause. ? pseudo seizure.

(P) → ECG - not remarkable, same as previous, ischaemic.
→ Bloods ie. cog/prothrombin/GAS/troponin/D-dimer/ethanol
→ VBG - Hc 43, ch 38.7.
→ IVF
→ No response to naloxone 2mg titrated dose.
→ Admit medics. - I will discuss with Dr A to see if would like to review in dept.
- If deteriorates will need intubated and CT(head).

Seizure approx 9pm :- 30secs, reactive to pain during due to supraclavicular pinch by Dr McNaughton.
:- No neurological deficit identified.
:- No meds to settle.

[signature]
07411061

Discharge Codes (Please CIRCLE)					Discharge date	
1. Admission	2. Discharge	3. Refer to GP	4. Transfer to other (see below)		Discharge time	
5. Died	6. Refer to OP Clinic (see below)		7. Irregular Discharge	8. D.O.A.		

Ward number (if admitted):	Transfer to hospital:	Consultant If admitted):

Follow up	Arranged			Not arranged			To be arranged	
Clinic referred to	A&E	Hand injury	Fracture	Pop Check	Medical	Surgical	ENT	Others (specify):

Discharge Prescription Packs

Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Frequency	Signature	Given By

Designed by Medical Illustration Services ref 243836

Date	CLINICAL NOTES
10/8/15	Seen by (Dr) BOSSLEY (LOCUM SHO SURG) Time seen 20[00].

(26) witnessed collapse

BACKGROUND
Mental health issues
Pancreatitis
Cocktails
Previous OOs

Drugs
Venlafaxine
Quetiapine

→ At approx 8pm was witnessed to be walking along corridor by passers by when he staggered, dropped the phone he was talking on and collapsed. No witnessed head injury. No seizure activity ° tongue biting, ° incontinence. Passersby advised nurse in ward 20 when I was working.

→ On attending, good output at both wrists, warm to touch, breathing freely but unresponsive, no verbal response, no eye opening, no response pain GCS 3.

→ TF to resus.

→ Removed unresponsive.

(A) patent, nil added sounds. Swells bilateral.

(B) Vesicular
RR 14
Sats 99% (ra)
° cyanosis.

Chest AE (R=L)
° wheeze
Nil focal.
Trachea central

(C) P 85 (regular)
BP 140/70
Warm peripherally

CRT < 2 secs.
Calves soft
° oedema.

(D) BM 6.2 on gas. Pupils perrla and NAD.

(E) Abdo scaphoid, soft, nontender. BS (N).
No external signs head injury. No chest wall trauma.
° Limb injuries noted.
PEARL, plantars ↓↓. Spastic movements of all 4 limbs.

Name: CHI:

NHS Greater Glasgow and Clyde

Acute Medical Unit Admission Proforma

MAU/A&E/AMU

Royal Alexandra Hospital, Paisley/Vale of Leven Hospital/IRH

Patient Details		
Name: **Address:**	1203893450 12/03/1989 WEIR James ht Sticker	**Sex:** F ☐ M ☐ **DoB** / / **Age:**
Telephone:	Dr. EC Renwick Quarryside Practice Linden Medical Centre 25 Floors Street Johnstone PA5 8PZ	
GP:		
Next of Kin:		
Telephone:		

Episode Details			
Date patient seen:	S VAMYA 11/8/15	**Time seen:** 0645	
Source of referral:	GP ☐ A&E ☑ OPD ☐ Self ☐ Other =		
Admitting Dr:	S VAMYA	**Grade** F42	**Bleep** 56548
Consultant:			

Resuscitation Decision

Resuscitation status: (please circle) **FOR RESUSCITATION / DNA CPR**

Signature: _____ **Name:** S. VAMYA **Grade:** F42

If DNA CPR → Complete appropriate form

97644

Name: CHI:

Presenting Complaint(s)	
Presenting complaint	Witnessed collapse + ? pseudoseizure
History of presenting complaint Hx from A+E clerk in	• was walking along street + passers by noticed pt staggering + then he dropped phone + collapsed – no head injury / °seizure activity, ° tongue biting, ° urinary incontinence. • Subsequently had an unresponsive episode GCS 3 which was short lived. • Also had a seizure lasting ~ 30 seconds resolved spontaneously • Pt remembers being w friend. Had been celebrating new job w buckfast. Thinks friend gave him something. Then was walking and then remembers being in resus and feeling unwell. • Reports feeling dizzy, sweaty, + RIF abd pain • No palpitations / chest pain.

Past Medical History / Review of Old Notes
• Severe mental health issues • Previous self harm, depression (neurosis) • gastritis •

Systemic Enquiry
CVS – nil RS – RIF tenderness pain – no radiation, not tender, bowels motion normal + bowel sounds normal. Resp – nil CNS – nil

Name: CHI:

MEDICINES RECONCILIATION – Acceptable to staple fully completed Emed Rec

Source of medication history Patient ☐ Relative/carer ☐ GP Phone call ☐ ECS ☑

(>1 source preferred) Patient own drugs ☐ Com. Pharmacist ☐ GP letter/summary ☐ Repeat Script ☐

Other (please specify) .....

Admission Medicines			Plan for medicines (Dr complete)				Comments
Name	Dose	Freq	Continue	Amend	Withold	Stop	Reason for alteration
Venlafaxine	75mg	od	✓				
Omeprazole	20mg	od	✓				

Allergies	List any over-the-counter or alternative medicines
None known ☑	
	Do medicines need further clarification ? Yes ☐ No ☐
List collected by : S. Sharma	Plan approved by :
Designation : F42 Date 11/8	Designation : Date :

Pharmacy review	Comments
Compliance aid : Yes ☐ No ☐	Community pharmacist Phone
Reviewed by :	Designation : Date :

Name: CHI:

Social History

Smoking History

Ex-smoker/Smoker ____cpd ___yrs Never smoked

Alcohol History

excess Units/week FAST score if excess _____

Recreational Drugs **Driving Status**

occasional

Social Circumstances (home, supports, functional status, occupation, travel)

Family History

Observations

BP: / **HR:** bpm **Sats:** % **FiO2:** **RR:** bpm **Temp:** °C **BM:**

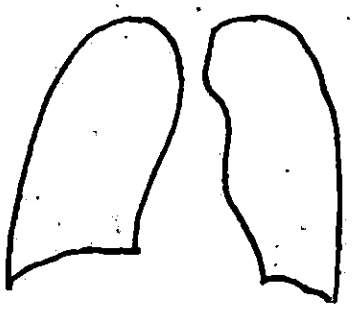
General Examination

General Appearance:

Cyanosis / pallor / jaundice / clubbing / lymphadenopathy

Respiratory

PEFR =



chest clear
equal AE bilaterally
; HSvT

Name: CHI:

Cardiovascular

Pulse regular **Heart Sounds** HS1+II+0

JVP –

Oedema nil

Peripheral Pulses palpable **cap refill** <2

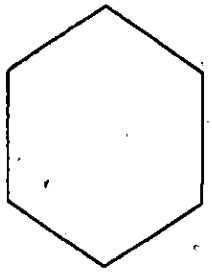
Gastrointestinal system

Masses: none

Organomegaly: none

Bowel sounds: normal

PR: NAD



Abdo SNT although has RIF pain

Neurological system

GCS: ~~3~~15 **E:** /4 **M:** /6 **V:** /5 **AMT:** /4 (AMT 4 = age, time, place, year)

Pupils/fundoscopy:

Cerebellar and extrapyramidal:

Cranial Nerves:

Neck:

Reflexes:



	RUL	LUL	RLL	LLL
Tone	N	N	N	N
Power	5	5	5	5
Co-ordination				
Sensation				

Plantars: R L

Locomotor

	Tender	Swollen	Deformity	Which joint?
Arms				
Legs				
Spine				

Gait:

Skin

Name: CHI:

Investigations

bloods
CXR
ECG

(Differential) diagnosis

- Collapse - ? cause
- ? psychiatric presentation

Management Plan

- monitor
- psych r/v.
- ? CT Head.

Thrombophrophylaxis assessed ☑ **Medicine Reconciliation** ☑ **DD6 if required** ☐

Signature S **PRINT NAME** S. CHAMA **PRINT GRADE** FY1 **Page:** S6548

11/8/15 02:50

Senior/Medical review ST3 MAYCOCK

Seen in A+E @ 2350 (written in retrospect)

PMH/Mental Health issues.

Collapse in Corridor
- initially attended A+E w/ chest pain.
- Collapsed in corridor between Surgery + way out.
- unwitnessed but found unresponsive

GCS 3/15 in A+E, Smelling of alcohol.
Apparent 'pseudoSeizure' activity in A+E.
- response to pain during 'fit'

Patient didn't really engage, however was GCS 15/15 when in was in the Resus Dept.

∴ P/ Admit to AMU for overnight Observation

My impression was Alcohol Intoxication

0850 Informed by Nursing Staff, patient absconded. He is not detainable ⇒ NO suicidal ideation, expressing self harm. Has 2x IV cannulas. Police Contacted - They will search but NOT DETAINABLE UNDER MHA

MAYCOCK ST3

Thrombophrophylaxis assessed ☐ **Medicine Reconciliation** ☐ **DD6 if required** ☐

MAYCOCK

Name: CHI:

Medical patient thromboprophylaxis decision aid – ENSURE BLACK BOX COMPLETED

Is the patient bed-bound or expected to have reduced mobility relative to normal for ≥2 days

Yes ☐ — No ☐

Does the patient have any of the following risk factors?	Tick if apply		Tick if apply
Active cancer or cancer treatment		Use of oestrogen containing contraceptive	
Age> 60		Hormone replacement therapy	
Dehydration		Pregnancy or <6 weeks post partum (seek specialist advice)	
Known thrombophillia		Critical care admission	
BMI >30		Varicose veins with phlebitis	
Personal/1st degree relative history of VTE		Current significant medical condition e.g. infection, inflammation, cardio resp disease	
Hip fracture			

- No thromboprophylaxis
- Reassess (every 72 hours minimum)and document
- Ensure patient informed of how to reduce risk of DVT (see information leaflet)

Yes ☐ — No ☐

Does the patient have any of the following contraindications?	Tick if apply		Tick if apply
Active bleeding		Untreated inherited bleeding disorder	
Acquired bleeding disorder		Thrombocytopaenia <75 x10^9/l	
Thyroid, spinal, posterior eye or neurosurgery		Other procedure with high bleeding risk (discuss with senior)	
Concurrent use of anticoagulants e.g. warfarin with INR>2		Uncontrolled hypertension (>230/120)	
Acute stroke		LP epidural or spinal within last 4 hours	
Recent (<4 hours) or expected (within 12 hours) lumbar puncture, epidural or spinal anaesthetic			
Other - Document			

- Discuss with senior clinical staff regarding thromboprophylaxis
- Ensure patient informed of how to reduce risk of DVT (see information leaflet)
- Consider mechanical prophylaxis unless contraindicated
- Reassess (every 72 hours minimum)and document

No ☐

Enoxaparin 40mg (reduce to 20mg if weighs < 50kg or eGFR <30) ☐

- Reassess every 72 hours minimum
- Ensure patient informed (see information leaflet)

Patient informed Yes ☐ N/A ☐
(only n/a if due to cognitive impairment or similar)

If N/A why? _____

Assessed by _____

Date _____

DD6 **All patients over 64**

4AT	Y/N/Na
Carers involved	Y/N/Na
Med rec	Y/N/Na
Sepsis Screen	Y/N/Na
Resuscitation status considered	Y/N
Discharge planning	Y/N/Na

Sepsis Six

Antibiotics within 1 hour	☐
Appropriate Cultures	☐
Fluids	☐
Oxygen	☐
Lactate	☐
Fluid balance, consider catheter	☐

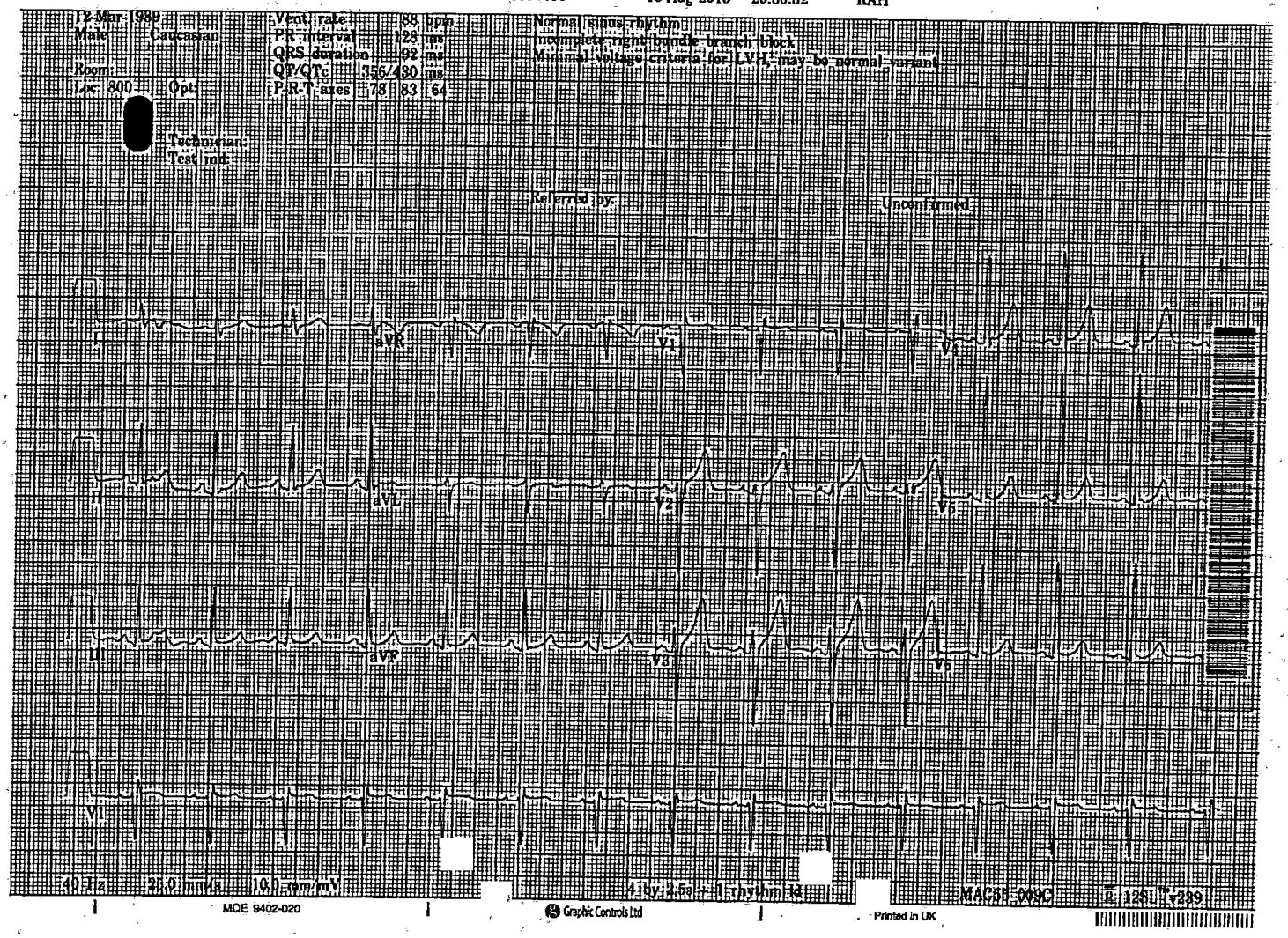
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Name: CHI:

Results

Date Time		11/8							
Parameter	Ref Range								
Hb	130-180	148							
WCC	4.0-11.0	5.7							
Plts	150-400	282							
MCV	78 - 99	96.0							
Neut	2.0 - 7.5	3.5							
PT	9.0 - 13.0	12							
APTT	27.0 - 38.0	36							
Fibrinogen	1.5-4gm/L								
INR	( )								
Thromb T	11-15 secs	15							
D-Dimer	<230								
Na^+	135 - 145	146							
K^+	3.5 - 5.0	3.9							
Cl^-	97 - 107	108							
HCO_3^-	23 - 30								
Urea	2.5 - 7.5	2.1							
Creat	62 - 124	69							
eGFR		60							
Glucose	3.5 - 5.9								
Protein	32 - 82								
Albumin	37 - 50								
AlkP	33 - 117								
Bil	0.5 - 19								
ALT	11 - 55								
AST	13 - 42								
GGT	8-60								
ESR									
CRP	<3	<1							
Troponin I hs	Men 0 - 34 Women 0 -16								
CK	23 - 190								
Corr Ca^{++}	2.25 - 2.60	2.14							
PO_4^-	0.8 - 1.4	1.50							
Mg^{++}	0.7 - 1.1								
Digoxin	0.5 – 2.0								
Alcohol									
Paracetamol	<100 @4 hr								
Salicylate									
AST	13 - 42								
Amylase	<100								
LDH	240 - 480								
Folate	3.1 - 20								
B12	200 - 900								
Ferritin	15 - 200								
TSH	0.35 – 5.00								
T4	9 - 21								

WEIR, JAMES ID: 1203893450 10-Aug-2015 20:36:32 RAH



Emergency Attendance Letter

NHS
Greater Glasgow and Clyde

Emergency Department
Royal Alexandra Hospital
Corsebar Road
Paisley
Renfrewshire
PA2 9PN

Dept. Contact Details:
Tel: 0141 314 6195
Fax: 0141 887 1386
Email:

Date Completed: 18/06/2026

Consultant: Dr Darren Thom

UH Rehman
Alba Medical Group Renfrewshire
Linden Medical Centre
25 Floors Street
Johnstone
Johnstone
PA5 8PZ

Dear UH Rehman

Re: **Weir James Thomas** DOB: **12/03/1989** CHI: **1203893450**
27D MACDOWALL STREET
Johnstone PA5 8QJ

Attended on: **17/06/2026 at 17:20 hrs.** Departed on: **17/06/2026 at 19:29 hrs.**
Discharge Type: **01a - Discharge with no follow up** Destination: **Private residence**
Previous ED Attendance in last 12 months: **0**

Presenting complaint
BIBP - lac to head

Nursing Assessment:
BIBP - Altercation whilst under arrest, patient hit head off fence with nails in fence. Laceration to left side of forehead and haematomata to centre of forehead. No Loc, GCS 15/15 Head injury SCALP HAEMATOMA

Investigations in ED: **None**

Diagnosis:

Diagnosis	Side	Site
Open Wound of Scalp		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **Please see Clinician Notes**

Clinician Notes:

Superficial wound to forehead. Normal neuro exam. Wound cleaned and closed with wound glue. Discharged with head injury advice into police custody

Followup :

Highly sensitive: N

Consent for sharing withheld: N

Yours sincerely,
Christopher Coubrough
Nurse

Copies to:

1. UH Rehman (GP)

School Address:

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

Emergency Department
Royal Alexandra Hospital
Corsebar Road
Paisley
Renfrewshire
PA2 9PN

Dept. Contact Details:
Tel: 0141 314 6195
Fax: 0141 887 1386
Email:

Date Completed: 12/05/2022

Consultant: Dr Kirsty Ray

JC Sim
Quarryside Medical Practice
Linden Medical Centre
25 Floors Street
Johnstone
Johnstone
PA5 8PZ

Dear JC Sim

Re: **Weir James** DOB: **12/03/1989** CHI: **1203893450**
27D MACDOWALL STREET
Johnstone PA5 8QJ

Attended on: **12/05/2022 at 09:20 hrs.** Departed on: **12/05/2022 at 14:07 hrs.**
Discharge Type: **01a - Discharge with no follow up** Destination: **Private residence**
Previous ED Attendance in last 12 months: **3**

Presenting complaint
biba chest pain

Nursing Assessment:
Chest pain central chest radaring to left. hx axs ?withdrawal, hx mh hx adad. Patient has stated to sas crew he has daily suicidal ideations, see reg with OMAR RDS.

Investigations in ED:

1. Urea and Electrolytes
2. Bicarbonate
3. LFT
4. Glucose
5. Lipid profile (inc. HDL)
6. Full Blood Count
7. XR Chest
8. Troponin I hs
9. Amylase
10. Bone Profile
11. Magnesium

Diagnosis:

Diagnosis	Side	Site
Other Chest Pain		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **Please see Clinician Notes**

Clinician Notes:

Chest and abdominal pain which he has had for years. Main concern appears to be his desire for an inpatient detox from alcohol. I have explained that this is not possible. Chest and abdominal examination normal except epigastric tenderness. CXR normal. ECG normal. Bloods showed a mild hypocalcaemia which I have treated. Could you please re-check his bone profile in a few weeks? He plans to contact his support worker on discharge

Followup :

Highly sensitive: N

Consent for sharing withheld: N

Yours sincerely,
Catriona Wallace
Consultant

Copies to:

1. JC Sim (GP)

School Address:

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

Emergency Department
Royal Alexandra Hospital
Corsebar Road
Paisley
Renfrewshire
PA2 9PN

Dept. Contact Details:
Tel: 0141 314 6195
Fax: 0141 887 1386
Email:

Date Completed: 21/04/2022

Consultant: Dr Iain Young

JC Sim
Quarryside Medical Practice
Linden Medical Centre
25 Floors Street
Johnstone
Johnstone
PA5 8PZ

Dear JC Sim

Re: **Weir James** DOB: **12/03/1989** CHI: **1203893450**
27D MACDOWALL STREET
Johnstone PA5 8QJ

Attended on: **21/04/2022 at 12:50 hrs.** Departed on: **21/04/2022 at 16:31 hrs.**
Discharge Type: **01a - Discharge with no follow up** Destination: **Private residence**
Previous ED Attendance in last 12 months: **2**

Presenting complaint
cut on left hand

Nursing Assessment:
cut to left and 1/7 ago

Investigations in ED:
1. XR Hand Lt

Diagnosis:

Diagnosis	Side	Site
Open Wound of Wrist and Hand, Part Unspecified		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **Please see Clinician Notes**

Clinician Notes:
Pt cut hand 1/7 ago with glass. No FB in wound. Cleaned and steristrips applied. Dressing placed.

Followup :
Highly sensitive: N

Consent for sharing withheld: N

Yours sincerely,
Ruth Barrie,
Doctor

Copies to:

1. JC Sim (GP)

School Address:

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

Emergency Department
Royal Alexandra Hospital
Corsebar Road
Paisley
Renfrewshire
PA2 9PN

Dept. Contact Details:
Tel: 0141 314 6195
Fax: 0141 887 1386
Email:

Date Completed: 22/04/2022

Consultant: Dr Santosh Bongale

JC Sim
Quarryside Medical Practice
Linden Medical Centre
25 Floors Street
Johnstone
Johnstone
PA5 8PZ

Dear JC Sim

Re: **Weir James** DOB: **12/03/1989** CHI: **1203893450**
27D MACDOWALL STREET
Johnstone PA5 8QJ

Attended on: **19/04/2022 at 01:23 hrs.** Departed on: **19/04/2022 at 05:13 hrs.**
Discharge Type: **01a - Discharge with no follow up** Destination: **Private residence**
Previous ED Attendance in last 12 months: **2**

Presenting complaint
Unconscious - BIBA

Nursing Assessment:
Member of public concerned James was un-conscious. Fully alert in triage and with crew. ?sleeping in close ? seizure gcs 15/15 pearl. c/o lower back pain. Known epilepsy and daily drinker.

Investigations in ED:
1. Full Blood Count
2. Coagulation screen
3. Urea and Electrolytes
4. LFT
5. Glucose
6. CRP
7. Amylase

Diagnosis:

Diagnosis	Side	Site
Person With Feared Complaint In Whom No Diagnosis Is Made		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **Please see Clinician Notes**

Clinician Notes:

Admits to being dependent on alcohol. Found by member of public outside flat ?unconscious. Patient stated was asleep after forgetting keys following visit to pub. Complaining of some 3/52 back pain, sounds muscular. Bloods, clinical examination & observations unremarkable. Long discussion re alcohol use & desire to cut down. States working with ARDS but unsure if needs I/P treatment. Longstanding low mood but no clear suicidal ideation in department. Will see GP/ARDS to discuss alcohol use. Worsening statement given re back pain.

Followup :

Highly sensitive: N

Consent for sharing withheld: N

Yours sincerely,
Lindsay Birch
Doctor

Copies to:

1. JC Sim (GP)

School Address:

Emergency Attendance Letter

NHS
Greater Glasgow and Clyde

Emergency Department
Royal Alexandra Hospital
Corsebar Road
Paisley
Renfrewshire
PA2 9PN

Dept. Contact Details:
Tel: 0141 314 6195
Fax: 0141 887 1386
Email:

Date Completed: 07/03/2022

Consultant: Dr Monica Wallace

JC Sim
Quarryside Medical Practice
Linden Medical Centre
25 Floors Street
Johnstone
Johnstone
PA5 8PZ

Dear JC Sim

Re: **Weir James** DOB: **12/03/1989** CHI: **1203893450**
27D MACDOWALL STREET
Johnstone PA5 8QJ

Attended on: **07/03/2022 at 18:40 hrs.**
Departed on: **07/03/2022 at 21:07 hrs.**
Discharge Type: **01c - Discharge with referral**
Destination: **Redirected to other Services**
Previous ED Attendance in last 12 months: **0**

Presenting complaint
Acute alcohol withdrawal, bibp

Nursing Assessment:
alcohol withdrawl feels suicide

Investigations in ED: **None**

Diagnosis:

Diagnosis	Side	Site
Mental and Behavioural Disorders due to Harmful Use of Alcohol		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **Please see Clinician Notes**

Clinician Notes:

Followup :

Highly sensitive: N

Consent for sharing withheld: N

Yours sincerely,
DRMonica Wallace
Consultant

Copies to:

1. JC Sim (GP)

School Address:

Emergency Attendance Letter

NHS
Greater Glasgow and Clyde

Emergency Department
Royal Alexandra Hospital
Corsebar Road
Paisley
Renfrewshire
PA2 9PN

Dept. Contact Details:
Tel: 0141 314 6195
Fax: 0141 887 1386
Email:

Date Completed: 19/06/2020

Consultant: Dr Neil Mukherjee

JC Sim
Quarryside Medical Practice
Linden Medical Centre
25 Floors Street
Johnstone
Johnstone
PA5 8PZ

Dear JC Sim

Re: **Weir James** DOB: **12/03/1989** CHI: **1203893450**
27D MACDOWALL STREET
Johnstone PA5 8QJ

Attended on: **11/06/2020 at 00:16 hrs.** Departed on: **11/06/2020 at 01:47 hrs.**
Discharge Type: **01a - Discharge with no follow up** Destination: **Private residence**
Previous ED Attendance in last 12 months: **1**

Presenting complaint
mhi

Nursing Assessment:
return to ED having been in an inpatient in AMU ? alcohol withdrawal diazepam given earlier no evidence of withdrawla in triage

Investigations in ED: **None**

Diagnosis:

Diagnosis	Side	Site
Mental and Behavioural Disorders due to Alcohol Dependence Syndrome		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:

Abusive to ward staff and patients, no ongoing clinical concern so asked to leave the ward area. Returned to ED. Verbally and then physically aggressive to ED staff, assaulted two staff members - asked to leave and police contacted.

Followup :

Highly sensitive: N Consent for sharing withheld: N

Yours sincerely,
Jessica Cooper
Doctor

Copies to:

1. JC Sim (GP)

School Address:

Emergency Attendance Letter

NHS
Greater Glasgow and Clyde

Emergency Department
Royal Alexandra Hospital
Corsebar Road
Paisley
Renfrewshire
PA2 9PN

Dept. Contact Details:
Tel: 0141 314 6195
Fax: 0141 887 1386
Email:

Date Completed: 29/08/2018

Consultant: Dr Chris MacDonald1

JC Sim
Quarryside Practice
Linden Medical Centre
25 Floors Street
Johnstone
Johnstone
PA5 8PZ

Dear JC Sim

Re: **Weir James** DOB: **12/03/1989** CHI: **1203893450**
27D MACDOWALL STREET
Johnstone PA5 8QJ

Attended on: **28/08/2018 at 23:20 hrs.** Departed on: **29/08/2018 at 02:51 hrs.**
Discharge Type: **01b - Discharge with follow up by primary care team** Destination: **Private residence**
Previous ED Attendance in last 12 months: **2**

Presenting complaint
suicidal

Nursing Assessment:
agitated and aggressive tonight stated he is suicidal, police called CPNs in community did not want to see James tonight.

Investigations in ED: **None**

Diagnosis:

Diagnosis	Side	Site
Symptoms and signs involving emotional state - Restlessness and agitation		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:

James was brought to the ED by two police officers following disruptive behaviour in his private residence. He was very agitated and upset in ED, also verbally and somewhat physically aggressive. Following repeat-conversation with CPN per telephone (CPN had spoken with patient and police while they were in his home, prior to their arrival in the ED), it was recommended that James get in touch with CPNs directly during working hours later today and a phone number provided. Although patient was unhappy with this decision, there was no justifiable reason to admit or detain him at the time. He was, thus, discharged back into police custody. Yours sincerely, Dr Emeka (GPST2)

Followup : **by primary care team**

Highly sensitive: N

Consent for sharing withheld: N

Yours sincerely,
Uchechi Emeka
Doctor

Copies to:

1. JC Sim (GP)

School Address:

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

Emergency Department
Royal Alexandra Hospital
Corsebar Road
Paisley
Renfrewshire
PA2 9PN

Dept. Contact Details:
Tel: 0141 314 6195
Fax: 0141 887 1386
Email:

Date Completed: 11/05/2018

Consultant: Dr Zoe Smeed

JC Sim
Quarryside Practice
Linden Medical Centre
25 Floors Street
Johnstone
Johnstone
PA5 8PZ

Dear JC Sim

Re: **Weir James** DOB: **12/03/1989** CHI: **1203893450**
27D MACDOWALL STREET
Johnstone PA5 8QJ

Attended on: **08/05/2018 at 17:39 hrs.** Departed on: **08/05/2018 at 18:51 hrs.**
Discharge Type: **04a - Incomplete: left before assessment completed** Destination: **Private residence**
Previous ED Attendance in last 12 months: **4**

Presenting complaint
Erratic - with police

Nursing Assessment:
low mood, suicidal ideation. audio disturbances previous self harm.

Investigations in ED: **None**

Diagnosis:

Diagnosis	Side	Site
Depression		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:

Brought in by police with suicidal ideation. Known depression, secondary to living situation - feels unsafe in current flat. Denied any on going suicidal plans. Did not wish to wait for psych assessment - had capacity so left prior to full assessment

Followup :

Highly sensitive: N

Consent for sharing withheld: N

Yours sincerely,
Diane OCarroll
Doctor

Copies to:

1. JC Sim (GP)

School Address:

Emergency Attendance Letter

NHS
Greater Glasgow and Clyde

Emergency Department
Royal Alexandra Hospital
Corsebar Road
Paisley
Renfrewshire
PA2 9PN

Dept. Contact Details:
Tel:
Fax: Patient attended the
Email: Medical Assessment Unit

Date Completed: 24/07/2017

Consultant: Dr Iain Keith

JC Sim
Quarryside Practice
Linden Medical Centre
25 Floors Street
Johnstone
Johnstone
PA5 8PZ

Dear JC Sim

Re: **Weir James** DOB: **12/03/1989** CHI: **1203893450**
27D MACDOWALL STREET
Johnstone PA5 8QJ

Attended on: **24/07/2017 at 17:08 hrs.** Departed on: **24/07/2017 at 20:06 hrs.**
Discharge Type: **01a - Discharge with no follow up** Destination: **Private residence**
Previous ED Attendance in last 12 months: **5**

Presenting complaint
Chest Infection

Nursing Assessment:

Investigations in ED:

1. Amylase
2. D - Dimer
3. Coagulation screen
4. Urea and Electrolytes
5. Glucose
6. LFT
7. CRP
8. Chol / Triglyceride
9. Full Blood Count
10. Troponin I hs
11. Blood Culture
12. XR Chest

Weir James CHI: 1203893450

Diagnosis:

Diagnosis	Side	Site
Viral infection, unspecified		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:

Primary and Important Co-Morbidities - Viral LRTI. Presenting symptoms - 6 Day history of some chest tightness. Had some pins and needles in hands. Today had half a bottle of buckfast. No other associated symptoms. Investigation results - Bloods unremarkable, Trop I negative, D-dimer negative Inflammatory markers normal. ECG Nil acute. CXR Nil focal. Management - Discharged home. Advised to take simple analgesia and fluids. Changes to medication - Nil Follow up and outpatient investigations - Nil

Followup :

Highly sensitive: N

Consent for sharing withheld: N

Yours sincerely,
Stephen Paterson
Nurse

Copies to:

1. JC Sim (GP)

School Address:

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

Emergency Department
Royal Alexandra Hospital
Corsebar Road
Paisley
Renfrewshire
PA2 9PN

Dept. Contact Details:
Tel: 0141 314 6195
Fax: 0141 887 1386
Email:

Date Completed: 22/06/2017

Consultant: Dr Neil Mukherjee

JC Sim
Quarryside Practice
Linden Medical Centre
25 Floors Street
Johnstone
Johnstone
PA5 8PZ

Dear JC Sim

Re: **Weir James** DOB: **12/03/1989** CHI: **1203893450**
27D MACDOWALL STREET
Johnstone PA5 8QJ

Attended on: **22/06/2017 at 14:58 hrs.** Departed on: **22/06/2017 at 18:50 hrs.**
Discharge Type: **01b - Discharge with follow up by primary care team** Destination: **Private residence**
Previous ED Attendance in last 12 months: **5**

Presenting complaint
suicidal

Nursing Assessment:
attended charleston centre today advised to attend rah

Investigations in ED: **None**

Diagnosis:

Diagnosis	Side	Site
Anxiety State		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:

Attended in crisis - unhappy with mental health services. Seen by on call psych and discharged with community follow up.

Followup :

Highly sensitive: N

Consent for sharing withheld: N

Yours sincerely,
James Patterson
Doctor

Copies to:

1. JC Sim (GP)

School Address:

Emergency Attendance Letter

NHS
Greater Glasgow and Clyde

Emergency Department
Royal Alexandra Hospital
Corsebar Road
Paisley
Renfrewshire
PA2 9PN

Dept. Contact Details:
Tel: 0141 314 6195
Fax: 0141 887 1386
Email:

Date Completed: 10/06/2017

Consultant: Dr Niall McMahon

JC Sim
Quarryside Practice
Linden Medical Centre
25 Floors Street
Johnstone
Johnstone
PA5 8PZ

Dear JC Sim

Re: **Weir James** DOB: **12/03/1989** CHI: **1203893450**
27D MACDOWALL STREET
Johnstone PA5 8QJ

Attended on: **09/06/2017 at 06:01 hrs.** Departed on: **09/06/2017 at 06:59 hrs.**
Discharge Type: **01a - Discharge with no follow up** Destination: **Private residence**
Previous ED Attendance in last 12 months: **4**

Presenting complaint
l/foot injury

Nursing Assessment:
Kicked door with instep R foot whilst at work yesterday. Since event c/o increased pain on mobilising. O/E swelling & bony tenderness medial malleolar zone & navicular R foot. Pedal pulse present, Sensation intact.

Investigations in ED:
1. XR Ankle Rt **2. XR Foot Rt**

Diagnosis:

Diagnosis	Side	Site
Sprain and strain of foot		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:

Followup :

Highly sensitive: N

Consent for sharing withheld: N

Yours sincerely,
Jude Stenhouse
Doctor

Copies to:

1. JC Sim (GP)

School Address:

Emergency Attendance Letter

NHS
Greater Glasgow and Clyde

Emergency Department
Royal Alexandra Hospital
Corsebar Road
Paisley
Renfrewshire
PA2 9PN

Dept. Contact Details:
Tel: 0141 314 6195
Fax: 0141 887 1386
Email:

Date Completed: 19/09/2016

Consultant: Dr Monica Wallace

EC Renwick
Quarryside Practice
Linden Medical Centre
25 Floors Street
Johnstone
Johnstone
PA5 8PZ

Dear EC Renwick

Re: **Weir James** DOB: **12/03/1989** CHI: **1203893450**
27D MACDOWALL STREET
Johnstone PA5 8QJ

Attended on: **19/09/2016 at 11:29 hrs.** Departed on: **at hrs.**
Discharge Type: **01a - Discharge with no follow up** Destination: **Private residence**
Previous ED Attendance in last 12 months: **5**

Presenting complaint
right foot pain

Nursing Assessment:

Investigations in ED:
1. XR Foot Rt

Diagnosis:

Diagnosis	Side	Site
Contusion of foot		

Procedures: **None**

Immunisations: **None**

Dispensed Medication:

Dispensed Medicine	Formulation	Dose	UOM	Route	Frequency	Duration
Cocodamol 30/500 2 tabs QID PREPACKED ONLY	**Tablets (PP)**	**2**	**TABS**	**Oral**	**FOUR Times a Day**	**No duration defined**

Clinician Notes:

Followup :
Highly sensitive: N

Consent for sharing withheld: N

Yours sincerely,
Iain Young
Consultant

Copies to:

1. EC Renwick (GP)

School Address:

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

Emergency Department
Royal Alexandra Hospital
Corsebar Road
Paisley
Renfrewshire
PA2 9PN

Dept. Contact Details:
Tel: 0141 314 6195
Fax: 0141 887 1386
Email:

Date Completed: 16/08/2016

Consultant: Dr Gordon McNaughton

EC Renwick
Quarryside Practice
Linden Medical Centre
25 Floors Street
Johnstone
Johnstone
PA5 8PZ

Dear EC Renwick

Re: **Weir James** DOB: **12/03/1989** CHI: **1203893450**
27D MACDOWALL STREET
Johnstone PA5 8QJ

Attended on: **16/08/2016 at 02:26 hrs.** Departed on: **16/08/2016 at 04:26 hrs.**
Discharge Type: **01a - Discharge with no follow up** Destination: **Private residence**
Previous ED Attendance in last 12 months: **4**

Presenting complaint
abdo pain

Nursing Assessment:
c/o upper L abdo pain since 01.45hrs, no vomiting.

Investigations in ED: **None**

Diagnosis:

Diagnosis	Side	Site
Pleurisy / Pleuritic chest pain		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:
Pleurisy- normal respiratory observations . ECG satisfactory. Home with simple analgesia. Worsening advice given.

Followup :
Highly sensitive: N

Consent for sharing withheld: N

Yours sincerely,
Gary Manson
Doctor Staff Grade

Copies to:

1. EC Renwick (GP)

School Address:

Emergency Attendance Letter

NHS
Greater Glasgow and Clyde

Emergency Department
Royal Alexandra Hospital
Corsebar Road
Paisley
Renfrewshire
PA2 9PN

Dept. Contact Details:
Tel: 0141 314 6195
Fax: 0141 887 1386
Email:

Date Completed: 11/08/2016

Consultant: Dr Gordon McNaughton

EC Renwick
Quarryside Practice
Linden Medical Centre
25 Floors Street
Johnstone
Johnstone
PA5 8PZ

Dear EC Renwick

Re: **Weir James** DOB: **12/03/1989** CHI: **1203893450**
27D MACDOWALL STREET
Johnstone PA5 8QJ

Attended on: **11/08/2016 at 10:55 hrs.** Departed on: **11/08/2016 at 14:50 hrs.**
Discharge Type: **03 - Transferred** Destination: **Transfer to other NHS healthcare provider**

Previous ED Attendance in last 12 months: **3**

Presenting complaint
suicidal

Nursing Assessment:
hearing voices telling him to kill himself and others. Hx mental health denies alcohol or substance abuse

Investigations in ED: **None**

Diagnosis:

Diagnosis	Side	Site
Suicidal Ideation		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:
Admitted to Dykebar

Followup :
Highly sensitive: N

Consent for sharing withheld: N

Yours sincerely,
DRMonica Wallace
Consultant

Copies to:

1. EC Renwick (GP)

School Address:

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

Emergency Department
Royal Alexandra Hospital
Corsebar Road
Paisley
Renfrewshire
PA2 9PN

Dept. Contact Details:
Tel: 0141 314 6195
Fax: 0141 887 1386
Email:

Date Completed: 19/07/2016

Consultant: Dr Alasdair Corfield

EC Renwick
Quarryside Practice
Linden Medical Centre
25 Floors Street
Johnstone
Johnstone
PA5 8PZ

Dear EC Renwick

Re: **Weir James** DOB: **12/03/1989** CHI: **1203893450**
27D MACDOWALL STREET
Johnstone PA5 8QJ

Attended on: **19/07/2016 at 10:12 hrs.** Departed on: **19/07/2016 at 13:28 hrs.**
Discharge Type: **01a - Discharge with no follow up** Destination: **Private residence**
Previous ED Attendance in last 12 months: **3**

Presenting complaint
abdo pains +vomiting blood

Nursing Assessment:
2/7 hx vomiting/ abdo pain, coffee ground vomit today.

Investigations in ED:

1. Urea and Electrolytes	**2. LFT**	**3. CRP**
4. Bicarbonate	**5. Gamma GT**	**6. Bone Profile**
7. Glucose	**8. Full Blood Count**	**9. Amylase**
10. Proteins		

Diagnosis:

Diagnosis	Side	Site
Alcoholic gastritis		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:

Followup :
Highly sensitive: N

Consent for sharing withheld: N

Yours sincerely,
Michael Carachi
Doctor

Copies to:

1. EC Renwick (GP)

School Address:

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

Emergency Department
Royal Alexandra Hospital
Corsebar Road
Paisley
Renfrewshire
PA2 9PN

Dept. Contact Details:
Tel: 0141 314 6195
Fax: 0141 887 1386
Email:

Date Completed: 02/06/2016

Consultant: Dr David Stoddart

EC Renwick
Quarryside Practice
Linden Medical Centre
25 Floors Street
Johnstone
Johnstone
PA5 8PZ

Dear EC Renwick

Re: **Weir James** DOB: **12/03/1989** CHI: **1203893450**
27D MACDOWALL STREET
Johnstone PA5 8QJ

Attended on: **02/06/2016 at 12:08 hrs.** Departed on: **02/06/2016 at 17:10 hrs.**
Discharge Type: **01a - Discharge with no follow up** Destination: **Private residence**
Previous ED Attendance in last 12 months: **2**

Presenting complaint
chest pain (biba)

Nursing Assessment:
chest pain nauseated smoked cannabis this morning, given maxalon by crew

Investigations in ED:

1. XR Chest	**2. Urea and Electrolytes**	**3. LFT**
4. CRP	**5. Bicarbonate**	**6. Gamma GT**
7. Bone Profile	**8. Glucose**	**9. Full Blood Count**
10. Amylase	**11. Proteins**	**12. Troponin I hs**

Diagnosis:

Diagnosis	Side	Site
Abdominal pain - Unspecified		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:

Feeling generally unwell last 2-3 days, intermittent chest heaviness, nausea and vomiting. On examination looks well, obs normal. Abdomen soft, tender epgastric, chest clear. Blood gas normal, bloods carried out including amylase and troponin normal. ECG nil acute. Abruptly stopped smoking cigarettes and cannabis 4 days ago, suspect this is the reason, advised regarding smoking cessation and discharged, to return if deterioration.

Followup:

Highly sensitive: N

Consent for sharing withheld: N

Yours sincerely,
Monica McGeough
Doctor

Copies to:

1. EC Renwick (GP)

School Address:

Emergency Attendance Letter

NHS
Greater Glasgow and Clyde

Emergency Department
Royal Alexandra Hospital
Corsebar Road
Paisley
Renfrewshire
PA2 9PN

Dept. Contact Details:
Tel: 0141 314 6195
Fax: 0141 887 1386
Email:

Date Completed: 12/11/2015

Consultant: Dr Victoria McWhinnie

EC Renwick
Quarryside Practice
Linden Medical Centre
25 Floors Street
Johnstone
Johnstone
PA5 8PZ

Dear EC Renwick

Re: **Weir James** DOB: **12/03/1989** CHI: **1203893450**
27D MACDOWALL STREET
Johnstone PA5 8QJ

Attended on: **03/11/2015 at 19:57 hrs.** Departed on: **03/11/2015 at 23:39 hrs.**
Discharge Type: **01a - Discharge with no follow up** Destination: **Private residence**
Previous ED Attendance in last 12 months: **7**

Presenting complaint
right hand injury

Nursing Assessment:
punched a wall last week

Investigations in ED:
1. XR Hand Rt

Diagnosis:

Diagnosis	Side	Site
Fracture of other metacarpal bone, closed	**Right**	**Hand**

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:

Patient presented to ED on 3/11/15 after punching a wall approx four days previously. Generalisd swelling to dorsum of hand with no focal tenderness. No obvious rotational deformity and sensation and circulation intact Undisplaced transverse fracture of base of 4th metacarpal reported on xray and identified 5/11/15. Patient had been seen and discharged by myself with advice to elevate hand to alleviate swelling and simple analgesia advice. I have tried repeatedly to contact the patient via telephone with no success to inform himof xray findings. I have therefore referred him to the fracture clinic on 9/11/15 for review and he will receive an appointment letter in due course. Apologies for the delay in this discharge letter.

Followup : **fracture clinic**

Highly sensitive: N

Consent for sharing withheld: N

Yours sincerely,
Victoria McWhinnie
Consultant

Copies to:

1. EC Renwick (GP)

School Address:

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

Emergency Department
Royal Alexandra Hospital
Corsebar Road
Paisley
Renfrewshire
PA2 9PN

Dept. Contact Details:
Tel: 0141 314 6195
Fax: 0141 887 1386
Email:

Date Completed: 10/08/2015

Consultant: Dr Gordon McNaughton

EC Renwick
Quarryside Practice
Linden Medical Centre
25 Floors Street
Johnstone
Johnstone
PA5 8PZ

Dear EC Renwick

Re: **Weir James** DOB: **12/03/1989** CHI: **1203893450**
27D MACDOWALL STREET
Johnstone PA5 8QJ

Attended on: **10/08/2015 at 19:24 hrs.**
Discharge Type: **02 - Admitted**
Previous ED Attendance in last 12 months: **9**

Departed on: **at hrs.**
Destination: **Admission to this Hospital**

Presenting complaint
chest pain

Nursing Assessment:

Investigations in ED:

1. XR Chest
2. Urea and Electrolytes
3. LFT
4. CRP
5. Bicarbonate
6. Gamma GT
7. Bone Profile
8. Glucose
9. Full Blood Count
10. Amylase
11. Proteins
12. Paracetamol
13. Salicylate
14. CK
15. Coagulation screen
16. Group and Save
17. Troponin I hs
18. D - Dimer

Diagnosis:

Diagnosis	Side	Site
Acute Alcohol intoxication		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:

Followup :
Highly sensitive: N

Consent for sharing withheld: N

Yours sincerely,
Gordon McNaughton
Consultant

Copies to:

1. EC Renwick (GP)

School Address:

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

Emergency Department
Royal Alexandra Hospital
Corsebar Road
Paisley
Renfrewshire
PA2 9PN

Dept. Contact Details:
Tel: 0141 314 6195
Fax: 0141 887 1386
Email:

Date Completed: 18/05/2015

Consultant: Dr Gordon McNaughton

EC Renwick
Quarryside Practice
Linden Medical Centre
25 Floors Street
Johnstone
Johnstone
PA5 8PZ

Dear EC Renwick

Re: **Weir James** DOB: **12/03/1989** CHI: **1203893450**
27D MACDOWALL STREET
Johnstone PA5 8QJ

Attended on: **18/05/2015 at 10:06 hrs.** Departed on: **18/05/2015 at 10:49 hrs.**
Discharge Type: **01a - Discharge with no follow up** Destination: **Private residence**
Previous ED Attendance in last 12 months: **13**

Presenting complaint
lower back injury

Nursing Assessment:
fell backwards 2 days ago. c/o , lower back pain

Investigations in ED: **None**

Diagnosis:

Diagnosis	Side	Site
Fracture of coccyx, closed		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:
clinical coccyx #. ambulant. home with analgesia and advice

Followup :
Highly sensitive: N

Consent for sharing withheld: N

Yours sincerely,
Niall McMahon
Consultant

Copies to:

1. EC Renwick (GP)

School Address:

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

Emergency Department
Royal Alexandra Hospital
Corsebar Road
Paisley
Renfrewshire
PA2 9PN

Dept. Contact Details:
Tel: 0141 314 6195
Fax: 0141 887 1386
Email:

Date Completed: 02/03/2015

Consultant: Dr Frank Westerduin

DA Foster
Dr D A Foster & Dr A E Crawford
The Health Centre
20 Duncan Street
Greenock
Greenock
PA15 4LY

Dear DA Foster

Re: **Weir James** DOB: **12/03/1989** CHI: **1203893450**
Flat D
Johnstone PA5 8QJ

Attended on: **01/03/2015 at 10:37 hrs.** Departed on: **01/03/2015 at 14:59 hrs.**
Discharge Type: **02 - Admitted** Destination: **Admission to this Hospital**
Previous ED Attendance in last 12 months: **12**

Presenting complaint
abdo pains +chest pain

Nursing Assessment:
hx. alcohol abuse , has had 4-6 bottles of buckfast yesterday woke up with chest/ abdominal pain this morning haematemesis, wants to set his house on fire states he has done this before

Investigations in ED:
1. XR Chest
2. Amylase
3. CK
4. CRP
5. Full Blood Count
6. Ethanol
7. Glucose
8. LFT
9. Urea and Electrolytes
10. Coagulation screen

Diagnosis:

Diagnosis	Side	Site
Chest pain, unspecified		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:
chest pain and abdo pain with 6 episodes of haematemesis. Admitted medics.

Followup :
Highly sensitive: N

Consent for sharing withheld: N

Yours sincerely,
Debbi Paterson
Doctor

Copies to:

1. DA Foster (GP)

School Address:

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

Emergency Department
Royal Alexandra Hospital
Corsebar Road
Paisley
Renfrewshire
PA2 9PN

Dept. Contact Details:
Tel: 0141 314 6195
Fax: 0141 887 1386
Email:

Date Completed: 02/03/2015

Consultant: Dr Frank Westerduin

DA Foster
Dr D A Foster & Dr A E Crawford
The Health Centre
20 Duncan Street
Greenock
Greenock
PA15 4LY

Dear DA Foster

Re: **Weir James** DOB: **12/03/1989** CHI: **1203893450**
Flat D
Johnstone PA5 8QJ

Attended on: **01/03/2015 at 00:40 hrs.** Departed on: **01/03/2015 at 04:03 hrs.**
Discharge Type: **01b - Discharge with follow up by primary care team** Destination: **Private residence**
Previous ED Attendance in last 12 months: **12**

Presenting complaint
suicidial/ intoxicated

Nursing Assessment:
contacted nhs 24 at 8pm last night saying he was feeling suicidal 2-3 bottles of buckfast since yesterday morning cpn could not properly assess pt due to alcohol intake pt c/o abdo pain and epigastric pain still feeling suicidal

Investigations in ED: **None**

Diagnosis:

Diagnosis	Side	Site
Depression		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:

Followup :

Highly sensitive: N

Consent for sharing withheld: N

Yours sincerely,
Jamie Adams
Doctor

Copies to:

1. DA Foster (GP)

School Address:

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

Emergency Department
Royal Alexandra Hospital
Corsebar Road
Paisley
Renfrewshire
PA2 9PN

Dept. Contact Details:
Tel: 0141 314 6195
Fax: 0141 887 1386
Email:

Date Completed: 17/12/2014

Consultant: Dr Alan Exton

CJ Johnstone
The Barony Practice
Northcroft Medical Centre
Paisley
Paisley
PA3 4AD

Dear CJ Johnstone

Re: **Weir James** DOB: **12/03/1989** CHI: **1203893450**
69C DUNDONALD ROAD
Paisley PA3 4NB

Attended on: **16/12/2014 at 23:59 hrs.** Departed on: **17/12/2014 at 03:00 hrs.**
Discharge Type: **01b - Discharge with follow up by primary care team** Destination: **Private residence**
Previous ED Attendance in last 12 months: **14**

Presenting complaint
suicidal

Nursing Assessment:
feeling suicidal, tearful and scared that he will hurt himself

Investigations in ED: **None**

Diagnosis:

Diagnosis	Side	Site
Suicidal Ideation		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:
Planned to hang or stab self. Brought in by police. Will get psych review

Followup :
Highly sensitive: N

Consent for sharing withheld: N

Yours sincerely,
Kate Schofield
Doctor

Copies to:

1. CJ Johnstone (GP)

School Address:

Emergency Attendance Letter

NHS
Greater Glasgow and Clyde

Emergency Department
Royal Alexandra Hospital
Corsebar Road
Paisley
Renfrewshire
PA2 9PN

Dept. Contact Details:
Tel: 0141 314 6195
Fax: 0141 887 1386
Email:

Date Completed: 11/12/2014

Consultant: Dr Alasdair Corfield

CJ Johnstone
The Barony Practice
Northcroft Medical Centre
Paisley
Paisley
PA3 4AD

Dear CJ Johnstone

Re: **Weir James** DOB: **12/03/1989** CHI: **1203893450**
69C DUNDONALD ROAD
Paisley PA3 4NB

Attended on: **03/12/2014 at 19:22 hrs.** Departed on: **03/12/2014 at 22:40 hrs.**
Discharge Type: **01a - Discharge with no follow up** Destination: **Private residence**
Previous ED Attendance in last 12 months: **14**

Presenting complaint
left shoulder injury

Nursing Assessment:
Pt came off a quad bike yesterday sustaining injury to (L) shoulder, arm and back. No head injury, has been to work today.

Investigations in ED:
1. XR Shoulder Lt **2. XR Chest**

Diagnosis:

Diagnosis	Side	Site
Unspecified injury of shoulder and upper arm		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:

fall from quadbike 24hrs before attended A&E, pain in shoulder and chest on deep breathing. Reduced range of motion on exmination. chest clear good air entry. X-ray of shoulder and chest did not show any fractures. Discharged with no follow up, advised to take simple analgesia. Wanted to leave before meds could be given.

Followup :

Highly sensitive: N

Consent for sharing withheld: N

Yours sincerely,
Michael Kinsella
Doctor

Copies to:

1. CJ Johnstone (GP)

School Address:

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

Emergency Department
Royal Alexandra Hospital
Corsebar Road
Paisley
Renfrewshire
PA2 9PN

Dept. Contact Details:
Tel: 0141 314 6195
Fax: 0141 887 1386
Email:

Date Completed: 19/08/2014

Consultant: Dr Santosh Bongale

A Sunderland
Kingsinch Medical Practice
Renfrew Health Centre
10 Ferry Road
Renfrew
Renfrew
PA4 8RU

Dear A Sunderland

Re: **Weir James** DOB: **12/03/1989** CHI: **1203893450**
3B MITCHELL AVENUE
Renfrew PA4 8DT

Attended on: **18/08/2014 at 22:01 hrs.** Departed on: **19/08/2014 at 03:22 hrs.**
Discharge Type: **01b - Discharge with follow up by primary care team** Destination: **Private residence**
Previous ED Attendance in last 12 months: **19**

Presenting complaint
abdo pain

Nursing Assessment:
d/c yest after alcohol withdrawal, feels symptoms have not resolved. c/o abdo pain and vomiting

Investigations in ED: **None**

Weir James CHI: 1203893450

Diagnosis:

Diagnosis	Side	Site
Alcoholic gastritis		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:

Abdominal pain. Describes 3 day hx of vomiting, sweating and lack of appetite. Descirbes geenral abdominal pain. NAD on examination. IMP: anxiety secondary to alchol withdrawal +/- alcohol related gastritis. Antiemetic, peptac and lansoprazole given. Supply of PPI given. advised to attend GP for support with alcohol withdrawal. Worsening advice given.

Followup :

Highly sensitive: N

Consent for sharing withheld: N

Yours sincerely,
Rachel Keltie
Doctor

Copies to:

1. A Sunderland (GP)

School Address:

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

Emergency Department
Royal Alexandra Hospital
Corsebar Road
Paisley
Renfrewshire
PA2 9PN

Dept. Contact Details:
Tel: 0141 314 6195
Fax: 0141 887 1386
Email:

Date Completed: 16/08/2014

Consultant: Dr Alasdair Corfield

A Sunderland
Kingsinch Medical Practice
Renfrew Health Centre
10 Ferry Road
Renfrew
Renfrew
PA4 8RU

Dear A Sunderland

Re: **Weir James** DOB: **12/03/1989** CHI: **1203893450**
3B MITCHELL AVENUE
Renfrew PA4 8DT

Attended on: **15/08/2014 at 17:43 hrs.** Departed on: **16/08/2014 at 00:23 hrs.**
Discharge Type: **01b - Discharge with follow up by primary care team** Destination: **Private residence**
Previous ED Attendance in last 12 months: **18**

Presenting complaint
exam

Nursing Assessment:
? overdose. Patient not verbalising. Noone with patient. SAS state patient was threatening to hang self earlier. GCS8 in triage. History of mental health problems

Investigations in ED: **None**

Diagnosis:

Diagnosis	Side	Site
Suicidal Ideation		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:

Followup :

Highly sensitive: N

Consent for sharing withheld: N

Yours sincerely,
Jamie Adams
Doctor

Copies to:

1. A Sunderland (GP)

School Address:

Emergency Attendance Letter

NHS
Greater Glasgow and Clyde

Emergency Department
Royal Alexandra Hospital
Corsebar Road
Paisley
Renfrewshire
PA2 9PN

Dept. Contact Details:
Tel: 0141 314 6195
Fax: 0141 887 1386
Email:

Date Completed: 16/08/2014

Consultant: Dr Niall McMahon

A Sunderland
Kingsinch Medical Practice
Renfrew Health Centre
10 Ferry Road
Renfrew
Renfrew
PA4 8RU

Dear A Sunderland

Re: **Weir James** DOB: **12/03/1989** CHI: **1203893450**
3B MITCHELL AVENUE
Renfrew PA4 8DT

Attended on: **13/08/2014 at 21:35 hrs.** Departed on: **14/08/2014 at 03:31 hrs.**
Discharge Type: **02 - Admitted** Destination: **Admission to this Hospital (triaged in A&E)**

Previous ED Attendance in last 12 months: **18**

Presenting complaint
chest pain

Nursing Assessment:
left sided chest pain for 3 days.

Investigations in ED:
1. Amylase
2. CRP
3. Full Blood Count
4. LFT
5. Urea and Electrolytes

Diagnosis:

Diagnosis	Side	Site
Chest pain, unspecified		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:

Followup :
Highly sensitive: N

Consent for sharing withheld: N

Yours sincerely,
Jamie Adams
Doctor

Copies to:
1. A Sunderland (GP)

School Address:

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

Emergency Department
Royal Alexandra Hospital
Corsebar Road
Paisley
Renfrewshire
PA2 9PN

Dept. Contact Details:
Tel: 0141 314 6195
Fax: 0141 887 1386
Email:

Date Completed: 02/07/2014

Consultant: Dr Alan Exton

DA Foster
Dr D A Foster & Dr A E Crawford
The Health Centre
20 Duncan Street
Greenock
Greenock
PA15 4LY

Dear DA Foster

Re: **Weir James** DOB: **12/03/1989** CHI: **1203893450**
69a Fitzalan Court
Paisley PA3 4UE

Attended on: **01/07/2014 at 23:15 hrs.** Departed on: **02/07/2014 at 05:03 hrs.**
Discharge Type: **01b - Discharge with follow up by primary care team** Destination: **Private residence**
Previous ED Attendance in last 12 months: **15**

Presenting complaint
found in close/exam

Nursing Assessment:
suicidal ideation

Investigations in ED: **None**

Diagnosis:

Diagnosis	Side	Site
Acute Alcohol intoxication		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:

Found sleeping in close. intoxiacted with alcohol. suicidal ideation in a&e. long history of alcohol and drug misuse. reveiwed by psychiatry - no evidence of psychosis or acute mental illness. alcohol and drug related. has appt with addictions team tomorrow. discharged home from a&e.

Followup :

Highly sensitive: N

Consent for sharing withheld: N

Yours sincerely,
Jenna McCormick
Doctor

Copies to:

1. DA Foster (GP)

School Address:

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

Emergency Department
Royal Alexandra Hospital
Corsebar Road
Paisley
Renfrewshire
PA2 9PN

Dept. Contact Details:
Tel: 0141 314 6195
Fax: 0141 887 1386
Email:

Date Completed: 28/06/2014

Consultant: Dr Alan Exton

DA Foster
Dr D A Foster & Dr A E Crawford
The Health Centre
20 Duncan Street
Greenock
Greenock
PA15 4LY

Dear DA Foster

Re: **Weir James** DOB: **12/03/1989** CHI: **1203893450**
THE HAVEN
Kilmacolm PA13 4TH

Attended on: **27/06/2014 at 22:58 hrs.** Departed on: **28/06/2014 at 00:00 hrs.**
Discharge Type: **01b - Discharge with follow up by primary care team** Destination: **Private residence**
Previous ED Attendance in last 12 months: **14**

Presenting complaint
suicidal

Nursing Assessment:
drinking buckfast tonight recently left the army (march) ? ptsd similar presentation earlier in the week

Investigations in ED: **None**

Diagnosis:

Diagnosis	Side	Site
Suicidal Ideation		
Acute Alcohol intoxication		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:

Patient seen in ED with identical presentation to last night, called NHS24 suicidal after smoking heroin, smoking cannabis and drinking coppious amounts of alcohol. Claims to have cut himself with a knife but refused to show this wound or tell me where it was. He was expressing homicidal ideation towards a man "Alex Walker" who he claims sexually assualted him and has recently been granted bail following a spell in prison. Pt very unforthcomming with information. Discharged into police care who will arrange for his transport home. For GP followup as per CPN recommendations from last night.

Followup :

Highly sensitive: N

Consent for sharing withheld: N

Yours sincerely,
Matthew Gawn
Doctor

Copies to:

1. DA Foster (GP)

School Address:

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

Emergency Department
Royal Alexandra Hospital
Corsebar Road
Paisley
Renfrewshire
PA2 9PN

Dept. Contact Details:
Tel: 0141 314 6195
Fax: 0141 887 1386
Email:

Date Completed: 27/06/2014

Consultant: Dr Raghavendra Nayak

DA Foster
Dr D A Foster & Dr A E Crawford
The Health Centre
20 Duncan Street
Greenock
Greenock
PA15 4LY

Dear DA Foster

Re: **Weir James** DOB: **12/03/1989** CHI: **1203893450**
THE HAVEN
Kilmacolm PA13 4TH

Attended on: **26/06/2014 at 20:35 hrs.** Departed on: **27/06/2014 at 04:20 hrs.**
Discharge Type: **01b - Discharge with follow up by primary care team** Destination: **Private residence**
Previous ED Attendance in last 12 months: **13**

Presenting complaint
mental health issue

Nursing Assessment:
hx psychiatric problems, tonight very stressed about personal issue. behaiving strangely in triage, not verbalising.

Investigations in ED: **None**

Diagnosis:

Diagnosis	Side	Site
Suicidal Ideation		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:

Distressed regarding personal issue relating to previous abuse. Chaotic lifestyle. No firm suicidal plan. Seen by psychiatry who felt it was appropriate to discharge.

Followup :

Highly sensitive: N

Consent for sharing withheld: N

Yours sincerely,
Veronica Mallon
Doctor

Copies to:

1. DA Foster (GP)

School Address:

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

Emergency Department
Royal Alexandra Hospital
Corsebar Road
Paisley
Renfrewshire
PA2 9PN

Dept. Contact Details:
Tel: 0141 314 6195
Fax: 0141 887 1386
Email:

Date Completed: 20/04/2014

Consultant: Dr Kirsty Ray

CJ Johnstone
The Barony Practice
Northcroft Medical Centre
Paisley
Paisley
PA3 4AD

Dear CJ Johnstone

Re: **Weir James** DOB: **12/03/1989** CHI: **1203893450**
1/7 17 ABERCORN STREET
Paisley PA3 4AA

Attended on: **15/04/2014 at 19:04 hrs.** Departed on: **15/04/2014 at 22:51 hrs.**
Discharge Type: **01a - Discharge with no follow up** Destination: **Private residence**
Previous ED Attendance in last 12 months: **13**

Presenting complaint
right sided abdo pain

Nursing Assessment:
c/o 72 hx abdo pain, vomitting, haemoptysis

Investigations in ED:
1. COAG screen (ED) **2. FBC (ED)**

Diagnosis:

Diagnosis	Side	Site
Urinary tract infection, site not specified		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:

Right sided abdominal pain. Urinary frequency. Tender renal angle. Positive urinalysis. Bloods unremarkable. Home with 2weeks of Trimethoprim. Advised to consider STI screen.

Followup :

Highly sensitive: N

Consent for sharing withheld: N

ours sincerely,
Catriona Considine
Doctor

Copies to:

1. CJ Johnstone (GP)

School Address:

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

Emergency Department
Royal Alexandra Hospital
Corsebar Road
Paisley
Renfrewshire
PA2 9PN

Dept. Contact Details:
Tel: 0141 314 6195
Fax: 0141 887 1386
Email:

Date Completed: 02/01/2014

Consultant: Dr Euan McMillan

A Sunderland
Kingsinch Medical Practice
Renfrew Health Centre
10 Ferry Road
Renfrew
Renfrew
PA4 8RU

Dear A Sunderland

Re: **Weir James** DOB: **12/03/1989** CHI: **1203893450**
17 Abercorn Street
Paisley PA3 4AA

Attended on: **02/01/2014 at 16:32 hrs.** Departed on: **02/01/2014 at 20:48 hrs.**
Discharge Type: **02 - Admitted** Destination: **Admission to this Hospital (triaged in A&E)**

Previous ED Attendance in last 12 months: **9**

Presenting complaint
seizure

Nursing Assessment:

Investigations in ED:
1. COAG screen (ED) **2. FBC (ED)** **3. LFT (ED)**
4. U&E's (ED)

Diagnosis:

Diagnosis	Side	Site
Acute Alcohol intoxication - Seizures		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:

Woke up on floor with pain all over, drinks excessively, decided not to drink any yesterday. lives in a homeless accomodation, told staff who called the ambulance. GCS 15 when seen, also reports coughing up fresh blood. Admitted under the medics.

Followup :

Highly sensitive: N

Consent for sharing withheld: N

Yours sincerely,
Sultan Ahmad
Doctor

Copies to:

1. A Sunderland (GP)

School Address:

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

Emergency Department
Royal Alexandra Hospital
Corsebar Road
Paisley
Renfrewshire
PA2 9PN

Dept. Contact Details:
Tel: 0141 314 6195
Fax: 0141 887 1386
Email:

Date Completed: 13/12/2013

Consultant: Dr Duncan Gray

A Sunderland
Kingsinch Medical Practice
Renfrew Health Centre
10 Ferry Road
Renfrew
Renfrew
PA4 8RU

Dear A Sunderland

Re: **Weir James** DOB: **12/03/1989** CHI: **1203893450**
17 Abercorn Street
Paisley PA3 4AA

Attended on: **12/12/2013 at 18:59 hrs.**
Discharge Type: **02 - Admitted**

Departed on: **12/12/2013 at 23:47 hrs.**
Destination: **Admission to this Hospital (triaged in A&E)**

Previous ED Attendance in last 12 months: **8**

Presenting complaint
pain left side

Nursing Assessment:

Investigations in ED:
1. Amylase (ED) **2. CRP (ED)** **3. FBC (ED)**
4. U&E's (ED) **5. LFT (ED)**

Diagnosis:

Diagnosis	Side	Site
Abdominal pain - Unspecified		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:

Patient presents with left iliac fossa pain , twisting pain worse with movement. Has associated vomiting a couple of times today. On examination he had left iliac fossa tenderness and also rebound tenderness. He was refered to the surgeons who reviewed and admitted him .

Followup :

Highly sensitive: N

Consent for sharing withheld: N

Yours sincerely,
Chukwuemeka Okonkwo
Doctor

Copies to:

1. A Sunderland (GP)

School Address:

Emergency Attendance Letter

NHS
Greater Glasgow and Clyde

Emergency Department
Royal Alexandra Hospital
Corsebar Road
Paisley
Renfrewshire
PA2 9PN

Dept. Contact Details:
Tel: 0141 314 6195
Fax: 0141 887 1386
Email:

Date Completed: 10/10/2013

Consultant: Dr Duncan Gray

A Sunderland
The Health Centre
103 Paisley Road
Renfrew
Renfrew
PA4 8LH

Dear A Sunderland

Re: **Weir James** DOB: **12/03/1989** CHI: **1203893450**
FLAT 2/1
Renfrew PA4 8HD

Attended on: **09/10/2013 at 20:25 hrs.** Departed on: **09/10/2013 at 23:50 hrs.**
Discharge Type: **01c - Discharge with referral** Destination: **Private residence**
Previous ED Attendance in last 12 months: **10**

Presenting complaint
suicidal

Nursing Assessment:
suicidal

Investigations in ED: **None**

Diagnosis:

Diagnosis	Side	Site
Suicidal Ideation		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:

Wrote a letter to key worker stating her would jump out a window. Still feeling suicidal in department. Wanting help with his alcohol problems. Seen by psychaitry who d/c him and he has follow up in the morning.

Followup :

Highly sensitive: N

Consent for sharing withheld: N

Yours sincerely,
Samantha Wilson
Doctor

Copies to:

1. A Sunderland (GP)

School Address:

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

Emergency Department
Royal Alexandra Hospital
Corsebar Road
Paisley
Renfrewshire
PA2 9PN

Dept. Contact Details:
Tel: 0141 314 6195
Fax: 0141 887 1386
Email:

Date Completed: 05/10/2013

Consultant: Dr Niall McMahon

A Sunderland
The Health Centre
103 Paisley Road
Renfrew
Renfrew
PA4 8LH

Dear A Sunderland

Re: **Weir James** DOB: **12/03/1989** CHI: **1203893450**
FLAT 2/1
Renfrew PA4 8HD

Attended on: **05/10/2013 at 00:00 hrs.**
Discharge Type: **02 - Admitted**

Departed on: **05/10/2013 at 04:56 hrs.**
Destination: **Admission to this Hospital (triaged in A&E)**

Previous ED Attendance in last 12 months: **9**

Presenting complaint
depression o/dose

Nursing Assessment:
suicidal/siezure

Investigations in ED:

1. **Bone CA/Phos (ED)**
2. **CK (ED)**
3. **CRP (ED)**
4. **FBC (ED)**
5. **Glucose (ED)**
6. **LFT (ED)**
7. **Magnesium (ED)**
8. **U&E's (ED)**

Diagnosis:

Diagnosis	Side	Site
Acute Hypnotic Intoxication - With seizures		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:
Admitted under medicine following seizure after ingesting unknown illicit drug.

Followup :
Highly sensitive: N

Consent for sharing withheld: N

Yours sincerely,
David Stewart
Doctor

Copies to:

1. A Sunderland (GP)

School Address:

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

Emergency Department
Royal Alexandra Hospital
Corsebar Road
Paisley
Renfrewshire
PA2 9PN

Dept. Contact Details:
Tel: 0141 314 6195
Fax: 0141 887 1386
Email:

Date Completed: 09/09/2013

Consultant: Dr Kirsty Ray

DC Davidson
The Consulting Rooms
21 Neilston Rd
Paisley
Paisley
PA2 6LW

Dear DC Davidson

Re: **Weir James** DOB: **12/03/1989** CHI: **1203893450**
12C THRUSHCRAIG CRESCENT
Paisley PA2 6PW

Attended on: **09/09/2013 at 22:03 hrs.** Departed on: **09/09/2013 at 22:50 hrs.**
Discharge Type: **01b - Discharge with follow up by primary care team** Destination: **Private residence**
Previous ED Attendance in last 12 months: **9**

Presenting complaint
personal

Nursing Assessment:

Investigations in ED: **None**

Diagnosis:

Diagnosis	Side	Site
Acute stress reaction		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:

struggling emotionally due to recent bereavement and alcohol excess wishes to stop drinking advised GP follow up for referral to CAT. has AA details. also suggested samaritans and breathing space as alternative supports

Followup :

Highly sensitive: N

Consent for sharing withheld: N

Yours sincerely,
Niall McMahon
Consultant

Copies to:

1. DC Davidson (GP)

School Address:

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

Emergency Department
Royal Alexandra Hospital
Corsebar Road
Paisley
Renfrewshire
PA2 9PN

Dept. Contact Details:
Tel: 0141 314 6195
Fax: 0141 887 1386
Email:

Date Completed: 01/09/2013

Consultant: Dr Frank Westerduin

SJ Pepper
Dedridge Medical Group
Dedridge Health Centre
Nigel Rise dedridge
Livingston
Livingston
EH54 6QQ

Dear SJ Pepper

Re: **Weir James** DOB: **12/03/1989** CHI: **1203893450**
Flat 0/2
Paisley PA2 6PW

Attended on: **01/09/2013 at 12:15 hrs.** Departed on: **01/09/2013 at 13:25 hrs.**
Discharge Type: **01a - Discharge with no follow up** Destination: **Private residence**
Previous ED Attendance in last 12 months: **8**

Presenting complaint
injury ribs/right knee & ankle

Nursing Assessment:

Investigations in ED:
1. XR Ankle Rt **2. XR Knee Rt**

Diagnosis:

Diagnosis	Side	Site
Contusion of chest wall		
Sprain and strain of knee, unspecified		
Sprain and strain of ankle		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:

Drinking last night, playing football and was sitting on the crossbar. Fell off onto right side. Complaining of pain in right ribs, right knee and right ankle. Tender right ribs, chest clear. Normal examination right knee and right ankle, but patient very sore therefore knee and ankle xrayed-no fracture seen. Discharged with analgesia.

Followup :

Highly sensitive: N

Consent for sharing withheld: N

Yours sincerely,
Emma Cullen
Registrar

Copies to:

1. SJ Pepper (GP)

School Address:

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

Emergency Department
Royal Alexandra Hospital
Corsebar Road
Paisley
Renfrewshire
PA2 9PN

Dept. Contact Details:
Tel: 0141 314 6195
Fax: 0141 887 1386
Email:

Date Completed: 29/08/2013

Consultant: Dr Euan McMillan

SJ Pepper
Dedridge Medical Group
Dedridge Health Centre
Nigel Rise dedridge
Livingston
Livingston
EH54 6QQ

Dear SJ Pepper

Re: **Weir James** DOB: **12/03/1989** CHI: **1203893450**
Flat 0/2
Paisley PA2 6PW

Attended on: **28/08/2013 at 23:20 hrs.** Departed on: **29/08/2013 at 05:15 hrs.**
Discharge Type: **01b - Discharge with follow up by primary care team** Destination: **Private residence**
Previous ED Attendance in last 12 months: **7**

Presenting complaint
o/dose

Nursing Assessment:

Investigations in ED:

1. Amylase (ED)
2. Bone CA/Phos (ED)
3. COAG screen (ED)
4. CRP (ED)
5. FBC (ED)
6. Glucose (ED)
7. LFT (ED)
8. Paracetamol (ED)
9. Salicylate (ED)
10. U&E's (ED)
11. COAG screen (ED)
12. LFT (ED)
13. Paracetamol (ED)
14. Salicylate (ED)
15. U&E's (ED)

Diagnosis:

Diagnosis	Side	Site
Depression		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:

Represented after being seen in A&E earlier in day. Previously assessed by psych. Reported paracetamol OD - levels not detected. Seen by psych again.

Followup :

Highly sensitive: N

Consent for sharing withheld: N

Yours sincerely,
Jennifer Ross
Doctor

Copies to:

1. SJ Pepper (GP)

School Address:

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

Emergency Department
Royal Alexandra Hospital
Corsebar Road
Paisley
Renfrewshire
PA2 9PN

Dept. Contact Details:
Tel: 0141 314 6195
Fax: 0141 887 1386
Email:

Date Completed: 28/08/2013

Consultant: Dr Charles Allister

SJ Pepper
Dedridge Medical Group
Dedridge Health Centre
Nigel Rise dedridge
Livingston
Livingston
EH54 6QQ

Dear SJ Pepper

Re: **Weir James** DOB: **12/03/1989** CHI: **1203893450**
28 Peveril Rise
Livingston EH54 6NU

Attended on: **28/08/2013 at 15:57 hrs.** Departed on: **28/08/2013 at 19:34 hrs.**
Discharge Type: **01a - Discharge with no follow up** Destination: **Private residence**
Previous ED Attendance in last 12 months: **6**

Presenting complaint
overdose/suicidal

Nursing Assessment:

Investigations in ED: **None**

Diagnosis:

Diagnosis	Side	Site
Acute stress reaction		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:

Acute traumatic stress disorder on background depression. Recently in Afghanistan as soldier - witnessed brother & friend shot dead. Suicidal; seeking help. Alcohol 3 pints lager today. Denies drug use or OD. Referred for psych assessment in ED - they advised fit for D/C; to attend GP surgery; alcohol referral within 48hrs. GP has already arranged post traumatic stress disorder therapy

Followup :

Highly sensitive: N

Consent for sharing withheld: N

Yours sincerely,
Marie-Ann Monnington
Doctor

Copies to:

1. SJ Pepper (GP)

School Address:

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

Emergency Department
Royal Alexandra Hospital
Corsebar Road
Paisley
Renfrewshire
PA2 9PN

Dept. Contact Details:
Tel: 0141 314 6195
Fax: 0141 887 1386
Email:

Date Completed: 26/04/2013

Consultant: Dr David Stoddart

SJ Pepper
Dedridge Medical Group
Dedridge Health Centre
Nigel Rise dedridge
Livingston
Livingston
EH54 6QQ

Dear SJ Pepper

Re: **Weir James** DOB: **12/03/1989** CHI: **1203893450**
28 Peveril Rise
Livingston EH54 6NU

Attended on: **26/04/2013 at 00:06 hrs.** Departed on: **at hrs.**
Discharge Type: **01a - Discharge with no follow up** Destination: **Private residence**
Previous ED Attendance in last 12 months: **7**

Presenting complaint
ankle injury

Nursing Assessment:
Found collapsed outside department.

Investigations in ED:
1. Paracetamol (ED) **2. Salicylate (ED)**

Diagnosis:

Diagnosis	Side	Site
No Injury or Abnormality Detected		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:
Claimed to have taken paracetamol. No levels detected

Followup :
Highly sensitive: N

Consent for sharing withheld: N

Yours sincerely,
.esley Brown
Doctor

Copies to:
1. SJ Pepper (GP)

School Address:

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

Emergency Department
Royal Alexandra Hospital
Corsebar Road
Paisley
Renfrewshire
PA2 9PN

Dept. Contact Details:
Tel: 0141 314 6195
Fax: 0141 887 1386
Email:

Date Completed: 25/04/2013

Consultant: Dr David Stoddart

SJ Pepper
Dedridge Medical Group
Dedridge Health Centre
Nigel Rise dedridge
Livingston
Livingston
EH54 6QQ

Dear SJ Pepper

Re: **Weir James** DOB: **12/03/1989** CHI: **1203893450**
28 Peveril Rise
Livingston EH54 6NU

Attended on: **25/04/2013 at 20:39 hrs.** Departed on: **at hrs.**
Discharge Type: **01c - Discharge with referral** Destination: **Private residence**
Previous ED Attendance in last 12 months: **6**

Presenting complaint
r ankle injury

Nursing Assessment:
kicked to back of ankle whilst playing football this evening. Since event c/o increased pain on mobilising

Investigations in ED:
1. XR Ankle Rt **2. XR Foot Rt**

Diagnosis:

Diagnosis	Side	Site
Sprain and strain of ankle		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:

Followup :
Highly sensitive: N

Consent for sharing withheld: N

Yours sincerely,
DAVID STODDART
Consultant

Copies to:
1. SJ Pepper (GP)

School Address:

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

Emergency Department
Royal Alexandra Hospital
Corsebar Road
Paisley
Renfrewshire
PA2 9PN

Dept. Contact Details:
Tel: 0141 314 6195
Fax: 0141 887 1386
Email:

Date Completed: 23/10/2012

Consultant: Dr Iain Young

CJ Johnstone
The Barony Practice
Northcroft Medical Centre
Paisley
Paisley
PA3 4AD

Dear CJ Johnstone

Re: **Weir James** DOB: **12/03/1989** CHI: **1203893450**
1/2 24 Maxwellton Street
Paisley PA1 2UB

Attended on: **26/08/2012 at 17:13 hrs.** Departed on: **26/08/2012 at 19:50 hrs.**
Discharge Type: **01a - Discharge with no follow up** Destination: **Private residence**
Previous ED Attendance in last 12 months: **35**

Presenting complaint
rec surg

Nursing Assessment:

Investigations in ED: **None**

Diagnosis:

Diagnosis	Side	Site
Surgical follow-up care, unspecified		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:

Followup :
Highly sensitive: N

Consent for sharing withheld: N

Yours sincerely,
Russell Potter
Doctor

Copies to:

1. CJ Johnstone (GP)

School Address:

Emergency Attendance Letter

NHS
Greater Glasgow and Clyde

Emergency Department
Royal Alexandra Hospital
Corsebar Road
Paisley
Renfrewshire
PA2 9PN

Dept. Contact Details:
Tel: 0141 314 6195
Fax: 0141 887 1386
Email:

Date Completed: 22/10/2012

Consultant: Dr Nicola MacInnes

CJ Johnstone
The Barony Practice
Northcroft Medical Centre
Paisley
Paisley
PA3 4AD

Dear CJ Johnstone

Re: **Weir James** DOB: **12/03/1989** CHI: **1203893450**
1/2 24 Maxwellton Street
Paisley PA1 2UB

Attended on: **22/10/2012 at 11:09 hrs.** Departed on: **22/10/2012 at 12:01 hrs.**
Discharge Type: **01a - Discharge with no follow up** Destination: **Private residence**
Previous ED Attendance in last 12 months: **35**

Presenting complaint
sutures burst on arm

Nursing Assessment:

Investigations in ED: **None**

Diagnosis:

Diagnosis	Side	Site
Attention to surgical dressings and sutures		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:

Followup :
Highly sensitive: N

Consent for sharing withheld: N

Yours sincerely,
Sam Ley
Doctor

Copies to:
1. CJ Johnstone (GP)

School Address:

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

Emergency Department
Royal Alexandra Hospital
Corsebar Road
Paisley
Renfrewshire
PA2 9PN

Dept. Contact Details:
Tel: 0141 314 6195
Fax: 0141 887 1386
Email:

Date Completed: 20/10/2012

Consultant: Dr Iain Young

CJ Johnstone
The Barony Practice
Northcroft Medical Centre
Paisley
Paisley
PA3 4AD

Dear CJ Johnstone

Re: **Weir James** DOB: **12/03/1989** CHI: **1203893450**
1/2 24 Maxwellton Street
Paisley PA1 2UB

Attended on: **20/10/2012 at 16:05 hrs.** Departed on: **at hrs.**
Discharge Type: **01b - Discharge with follow up by primary care team** Destination: **Not known**
Previous ED Attendance in last 12 months: **34**

Presenting complaint
left wrist laceration

Nursing Assessment:
dsh lac to left arm with clean kitchen knife no intention of suicide

Investigations in ED: **None**

Diagnosis:

Diagnosis	Side	Site
Open wound of forearm	**Left**	

Procedures: **1. Local anaesthetic infiltration**
2. Sutures other

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:
3 nylon sutures. ROS 6/7 pls, Revaxis given

Followup :
Highly sensitive: N

Consent for sharing withheld: N

Yours sincerely,
Neil Mukherjee
Consultant

Copies to:
1. CJ Johnstone (GP)

School Address:

Emergency Attendance Letter

NHS
Greater Glasgow and Clyde

Emergency Department
Royal Alexandra Hospital
Corsebar Road
Paisley
Renfrewshire
PA2 9PN

Dept. Contact Details:
Tel: 0141 314 6195
Fax: 0141 887 1386
Email:

Date Completed: 16/10/2012

Consultant: Dr Gordon McNaughton

CJ Johnstone
The Barony Practice
Northcroft Medical Centre
Paisley
Paisley
PA3 4AD

Dear CJ Johnstone

Re: **Weir James** DOB: **12/03/1989** CHI: **1203893450**
1/2 24 Maxwellton Street
Paisley PA1 2UB

Attended on: **03/10/2012 at 00:57 hrs.** Departed on: **03/10/2012 at 04:36 hrs.**
Discharge Type: **02 - Admitted** Destination: **Admission to this Hospital (triaged in A&E)**

Previous ED Attendance in last 12 months: **33**

Presenting complaint
collapse

Nursing Assessment:

Investigations in ED:
1. **Glucose (ED)**
2. **F (ED)**
3. **H L (ED)**
4. **F s (ED)**
5. **LF (ED)**
6. **&E s (ED)**

Diagnosis: **one**

Procedures: **one**

Immunisations: **one**

Dispensed Medication: **one**

Clinician Notes:

Followup :
Highly sensitive: N

Consent for sharing withheld: N

Yours sincerely,
Russell Potter
Doctor

Copies to:

1. CJ Johnstone (GP)

School Address:

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

Emergency Department
Royal Alexandra Hospital
Corsebar Road
Paisley
Renfrewshire
PA2 9PN

Dept. Contact Details:
Tel: 0141 314 6195
Fax: 0141 887 1386
Email:

Date Completed: 16/10/2012

Consultant: Dr Charles Allister

CJ Johnstone
The Barony Practice
Northcroft Medical Centre
Paisley
Paisley
PA3 4AD

Dear CJ Johnstone

Re: **Weir James** DOB: **12/03/1989** CHI: **1203893450**
1/2 24 Maxwellton Street
Paisley PA1 2UB

Attended on: **14/10/2012 at 20:00 hrs.** Departed on: **14/10/2012 at 20:40 hrs.**
Discharge Type: **04a - Incomplete: left before assessment completed** Destination: **Not known**
Previous ED Attendance in last 12 months: **33**

Presenting complaint
seizures

Nursing Assessment:

Investigations in ED: **None**

Diagnosis: **None**

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:

Followup :
Highly sensitive: N

Consent for sharing withheld: N

Yours sincerely,
Russell Potter
Doctor

Copies to:

1. CJ Johnstone (GP)

School Address:

Emergency Attendance Letter

NHS
Greater Glasgow and Clyde

Emergency Department
Royal Alexandra Hospital
Corsebar Road
Paisley
Renfrewshire
PA2 9PN

Dept, Contact Details:
Tel: 0141 314 6195
Fax: 0141 887 1386
Email:

Date Completed: 01/06/2012

Consultant: Dr Lucy Thomas

CD MacKenzie
Craiglockhart Medical Group
Craiglockhart Surgery
161 Colinton Road
Edinburgh
Edinburgh
EH14 1BE

Dear CD MacKenzie

Re: **Weir James** DOB: **12/03/1989** CHI: **1203893450**
23 Oxgangs House
Edinburgh EH13 9HE

Attended on: **31/05/2012 at 23:20 hrs.** Departed on: **01/06/2012 at 00:49 hrs.**
Discharge Type: **01a - Discharge with no follow up** Destination: **Private residence**
Previous ED Attendance in last 12 months: **30**

Presenting complaint
Laceration to left hand

Nursing Assessment:

Investigations in ED: **None**

Diagnosis:

Diagnosis	Side	Site
Open wound of finger(s) without damage to nail		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:

Followup :
Highly sensitive: N

Consent for sharing withheld: N

Yours sincerely,
GARY MANSON
Doctor Staff Grade

Copies to:

1. A Latif (GP)
2. CD MacKenzie (GP)

School Address:

HOSPITAL INFORMATION MISSING



Dr COLIN MACKENZIE
CRAIGLOCKHART SURGERY
161 COLINTON ROAD EDINBURGH

EH14 1BE

Date : 23 Dec 2011

Dear Dr COLIN MACKENZIE,

Re: JAMES WEIR, 72/1 STOCK STREET, PAISLEY, PA2 6NJ
Date of Birth: 12/03/1989 CHI number: 1203893450

HOSPITAL INFORMATION MISSING Patient attended on the 23 Dec 2011.

The presenting complaint was: **ASSAULTED (FACIAL INJURY)**

Triage information:	**PAIN? , RECENT PROBLEM? SEE NURSING SHEET**
The following investigations were carried out:	**None**
The A&E diagnosis was:	**LACERATION - FACE - FRONT**
The following treatment was given:	**HEAD INJURY ADVICE CARD GIVEN** **EPISTAXIS/NOSE INJURY ADVICE CARD GIVEN** **TISSUE GLUE**
At the conclusion of treatment the patient was:	**DISCHARGED - NO FOLLOW UP REQUIRED**

Follow-up: **NO FOLLOW UP ARRANGED**

Additional information: **None**

Yours sincerely,

DOUGLAS WINCH

EMERG MED DOCTOR

HOSPITAL INFORMATION MISSING



Dr COLIN MACKENZIE
CRAIGLOCKHART SURGERY
161 COLINTON ROAD EDINBURGH

EH14 1BE

Date : 13 Oct 2011

Dear Dr COLIN MACKENZIE,

Re: JAMES WEIR, 23 Oxgangs House, Oxgangs Grove, Oxgangs, EDINBURGH, EH13 9HE
Date of Birth: 12/03/1989 CHI number: 1203893450

HOSPITAL INFORMATION MISSING Patient attended on the 13 Oct 2011.

The presenting complaint was: **TAKEN 70 PARACETAMOL ?**

Triage information: **Not recorded**

The following investigations were carried out: **None**

The A&E diagnosis was: **NONE ASSIGNED IN EDIS**

The following treatment was given: **None**

At the conclusion of treatment the patient was: **DIRECT REFERRAL TO MAU RAH**

Follow-up: **Not recorded**

Additional information: **None**

Yours sincerely,

NONE ASSIGNED IN EDIS

NONE ASSIGNED IN EDIS

HOSPITAL INFORMATION MISSING



Dr ABID MAHMOOD
The Tannahill Centre
76 Blackstoun Road Paisley

PA3 1NT

Date : 21 Jun 2011

Dear Dr ABID MAHMOOD,

Re: JAMES WEIR, 76 STOCK STREET, PAISLEY, PA2 6NH
Date of Birth: 12/03/1989 CHI number: 1203893450

HOSPITAL INFORMATION MISSING Patient attended on the 21 Jun 2011.

The presenting complaint was: **CHEST PAIN**

Triage information: **Not recorded**

The following investigations were carried out:

U&E'S
GLUCOSE
LFT
BONE CA/PHOS
GAMMA GT
CRP
PARACETAMOL
SALICYLATE
FULL BLOOD COUNT FBC
COAG SCREEN

The A&E diagnosis was:

SELF HARM - BY POISONING FROM DRUGS, MEDICATIONS OR OTHER SUBSTANCES

The following treatment was given:	**None**
At the conclusion of treatment the patient was:	**ADMITTED RAH**
Follow-up:	**RAH ACUTE MEDICAL UNIT**
Additional information:	**None**

Yours sincerely,

ALASDAIR MCRITCHIE

EMERG MED DOCTOR

HOSPITAL INFORMATION MISSING



Dr ABID MAHMOOD
The Tannahill Centre
76 Blackstoun Road Paisley

PA3 1NT

Date : 07 Mar 2011

Dear Dr ABID MAHMOOD,

Re: JAMES WEIR, 34 Candren Road, PAISLEY, PA3 1DW
Date of Birth: 12/03/1989 CHI number: 1203893450

HOSPITAL INFORMATION MISSING Patient attended on the 07 Mar 2011.

The presenting complaint was: **INJURY TO R ANKLE**

Triage information:	**Not recorded**
The following investigations were carried out:	**FOOT X-RAY - RIGHT** **ANKLE X-RAY - RIGHT**
The A&E diagnosis was:	**SOFT TISSUE INJURY - FOOT - RIGHT**
The following treatment was given:	**ADVICE GIVEN** **ADVICE RE ICE & MOBILISATION** **ADVISED TO RETURN IF NECESSARY** **PARACETAMOL 500MG. 1-2 TABS 4-6 HOURLY** **PRN-10 TABS SUPPLIED** **DOUBLE TUBIGRIP**

At the conclusion of treatment the patient was:	**DISCHARGED - NO FOLLOW UP REQUIRED**
Follow-up:	**NO FOLLOW UP ARRANGED**
Additional information:	**No bony injury seen on xray.**

Yours sincerely,

TRACY SMITH

EMERGENCY NURSE PRACTITIONER

EMERGENCY DEPARTMENT
ROYAL ALEXANDRA HOSPITAL
CORSEBAR ROAD
PAISLEY
PA2 9PN

NHS
Greater Glasgow and Clyde

Dr ABID MAHMOOD
The Tannahill Centre
76 Blackstoun Road Paisley
PA3 1NT

Date: 30 Sep 2009

Dear Dr ABID MAHMOOD,

Re: JAMES WEIR, 34 CANDREN ROAD, PAISLEY,
Date of Birth: 12/03/1989 CHI number: 1203893450

Your patient attended Royal Alexandra Hospital on the 29 Sep 2009.

The presenting complaint was:	**HIT BY CAR**
Triage information:	**Not recorded**
The following investigations were carried out:	**PELVIS X-RAY** **FEMUR X-RAY - RIGHT** **KNEE X-RAY - RIGHT** **TIBIA & FIBULA X-RAY - RIGHT** **CERVICAL SPINE X-RAYS**
The A&E diagnosis was:	**CLOSED FRACTURE - KNEE - RIGHT**
The following treatment was given:	**None**
At the conclusion of treatment the patient was:	**Not specified**
Follow-up:	**Not recorded**
Additional information:	**None**

Yours sincerely,

GORDON MCNEISH
DOCTOR

EMERGENCY DEPARTMENT
ROYAL ALEXANDRA HOSPITAL
CORSEBAR ROAD
PAISLEY
PA2 9PN

NHS
Greater Glasgow and Clyde

Dr ABID MAHMOOD
The Tannahill Centre
76 Blackstoun Road Paisley
PA3 1NT

Date: 06 Oct 2008

Dear Dr ABID MAHMOOD,

Re: JAMES WEIR, 34 Candren Road, PAISLEY, Renfrewshire, PA3 1DW
Date of Birth: 12/03/1989 CHI number: 1203893450

Your patient attended Royal Alexandra Hospital on the 06 Oct 2008.

The presenting complaint was:	**LEFT FINGER INJURY**
Triage information:	**SUPERFICIAL LAC TO RING FINGER. APPEARS MACERATED DUE TO DRESSING AND CELLOTAPE APPLIED TO SAME. PT STATES CAUSED BY WOOD , PAIN?**
The following investigations were carried out:	**None**
The A&E diagnosis was:	**LACERATION - FINGER-RING - LEFT**
The following treatment was given:	**None**
At the conclusion of treatment the patient was:	**Not specified**
Follow-up:	**Not recorded**
Additional information:	**None**

Yours sincerely,

YVONNE MOULDS
EMERG MED DOCTOR

EMERGENCY DEPARTMENT
ROYAL ALEXANDRA HOSPITAL
CORSEBAR ROAD
PAISLEY
PA2 9PN

NHS
Greater Glasgow and Clyde

Dr ABID MAHMOOD
The Tannahill Centre
76 Blackstoun Road Paisley
PA3 1NT

Date: 05 Oct 2008

Dear Dr ABID MAHMOOD,

Re: JAMES WEIR, 34 CANDREN ROAD, PAISLEY,
Date of Birth: 12/03/1989 CHI number: 1203893450

'our patient attended Royal Alexandra Hospital on the 05 Oct 2008.

The presenting complaint was:	**INJURY TO FINGERS LEFT HAND**
Triage information:	**Not recorded**
The following investigations were carried out:	**None**
The A&E diagnosis was:	**NONE ASSIGNED IN EDIS**
The following treatment was given:	**None**
At the conclusion of treatment the patient was:	**INCOMPLETE - PATIENT LEFT BEFORE ASSESSMENT COMPLETED**
Follow-up:	**Not recorded**
Additional information:	**None**

'ours sincerely,

YVONNE MOULDS
EMERG MED DOCTOR

EMERGENCY DEPARTMENT
ROYAL ALEXANDRA HOSPITAL
CORSEBAR ROAD
PAISLEY
PA2 9PN

NHS
Greater Glasgow and Clyde

Dr ABID MAHMOOD
The Tannahill Centre
76 Blackstoun Road Paisley
PA3 1NT

Date: 22 Mar 2008

Dear Dr ABID MAHMOOD,

Re: JAMES WEIR, 34 Candren Road, PAISLEY, Renfrewshire, PA3 1DW
Date of Birth: 12/03/1989 CHI number: 1203893450

Your patient attended Royal Alexandra Hospital on the 22 Mar 2008.

The presenting complaint was:	**CHIN LACERATION**
Triage information:	**FELL YESTERDAY PM , ? BANGING FACE ON GROUND. PATIENT STATES HAD DRANK ALCOHOL TO EXCESS, HAS LITTLE RECOLLECTION OF EVENTS. O/A ALERT ORIENATED LACERATION TO CHIN. , PAIN?**
The following investigations were carried out:	**OPT, AP & OBLIQUES MANDIBLE**
The A&E diagnosis was:	**ABRASION - FACE - FRONT**
The following treatment was given:	**None**
At the conclusion of treatment the patient was:	**Not specified**
Follow-up:	**Not recorded**
Additional information:	**None**

Yours sincerely,

CHRIS MILNE
DOCTOR

EMERGENCY DEPARTMENT
ROYAL ALEXANDRA HOSPITAL
CORSEBAR ROAD
PAISLEY
PA2 9PN

NHS
Greater Glasgow and Clyde

Dr ABID MAHMOOD
The Tannahill Centre
76 Blackstoun Road Paisley
PA3 1NT

Date: 14 Mar 2008

Dear Dr ABID MAHMOOD,

Re: JAMES WEIR, 34 Candren Road, PAISLEY, Renfrewshire, PA3 1DW
Date of Birth: 12/03/1989 CHI number: 1203893450

Your patient attended Royal Alexandra Hospital on the 14 Mar 2008.

The presenting complaint was:	**UNWELL ADULT**
Triage information:	**Not recorded**
The following investigations were carried out:	**None**
The A&E diagnosis was:	**ACCIDENTAL POISONING A11 - BY AND EXPOSURE TO ALCOHOL** **ACCIDENTAL POISONING A11 - EXPOSURE TO OTHER UNSPECIFIED DRUGS, MEDICATIONS, OR BIOLOGICAL SUBSTANCES.**
The following treatment was given:	**None**
At the conclusion of treatment the patient was:	**Not specified**
Follow-up:	**Not recorded**
Additional information:	**None**

Yours sincerely,

GORDON MCNAUGHTON
CONSULTANT IN EMERGENCY MEDICINE

EMERGENCY DEPARTMENT
ROYAL ALEXANDRA HOSPITAL
CORSEBAR ROAD
PAISLEY
PA2 9PN

NHS
Greater Glasgow and Clyde

Dr ABID MAHMOOD
The Tannahill Centre
76 Blackstoun Road Paisley
PA3 1NT

Date: 11 Mar 2008

Dear Dr ABID MAHMOOD,

Re: JAMES WEIR, 34 CANDREN ROAD, PAISLEY,
Date of Birth: 12/03/1989 CHI number: 1203893450

our patient attended Royal Alexandra Hospital on the 11 Mar 2008.

The presenting complaint was:	**CHEST PAIN**
Triage information:	**MODERATE PAIN?**
The following investigations were carried out:	**None**
The A&E diagnosis was:	**MUSCULO-SKELETAL (NON TRAUMA) A9 - MUSCULO-SKELETAL PAIN OF CHEST**
The following treatment was given:	**CO-CODAMOL 8/500. 1-2 TABS,4-6 HOURLY PRN (20 TABS SUPPLIED)**
At the conclusion of treatment the patient was:	**Not specified**
Follow-up:	**Not recorded**
Additional information:	**None**

Yours sincerely,

ALAN MCLAY
EMERG MED DOCTOR

EMERGENCY DEPARTMENT
ROYAL ALEXANDRA HOSPITAL
CORSEBAR ROAD
PAISLEY
PA2 9PN

NHS
Greater Glasgow and Clyde

Dr ABID MAHMOOD
The Tannahill Centre
76 Blackstoun Road Paisley
PA3 1NT

Date: 27 Feb 2008

Dear Dr ABID MAHMOOD,

Re: JAMES WEIR, 34 Candren Road, PAISLEY, Renfrewshire, PA3 1DW
Date of Birth: 12/03/1989 CHI number: 1203893450

'our patient attended Royal Alexandra Hospital on the 27 Feb 2008.

The presenting complaint was:	**QUERY FALL**
Triage information:	**HAS BEEN DRINKING VODKA AND BUCKFAST , RECENT PROBLEM?**
The following investigations were carried out:	**None**
The A&E diagnosis was:	**NONE ASSIGNED IN EDIS**
The following treatment was given:	**None**
At the conclusion of treatment the patient was:	**INCOMPLETE - PATIENT LEFT BEFORE ASSESSMENT COMPLETED**
Follow-up:	**Not recorded**
Additional information:	**None**

ours sincerely,

NONE ASSIGNED IN EDIS
NONE ASSIGNED IN EDIS

EMERGENCY DEPARTMENT
ROYAL ALEXANDRA HOSPITAL
CORSEBAR ROAD
PAISLEY
PA2 9PN

NHS
Greater Glasgow and Clyde

Dr ABID MAHMOOD
The Tannahill Centre
76 Blackstoun Road Paisley
PA3 1NT

Date: 04 Feb 2008

Dear Dr ABID MAHMOOD,

Re: JAMES WEIR, 34 Candren Road, PAISLEY, Renfrewshire, PA3 1DW
Date of Birth: 12/03/1989 CHI number: 1203893450

Your patient attended Royal Alexandra Hospital on the 04 Feb 2008.

The presenting complaint was:	**OVERDOSE**
Triage information:	**INAPROPRIATE HISTORY?**
The following investigations were carried out:	**None**
The A&E diagnosis was:	**ACCIDENTAL POISONING A11 - NOXIOUS SUBSTANCE EATEN AS FOOD**
The following treatment was given:	**None**
At the conclusion of treatment the patient was:	**Not specified**
Follow-up:	**Not recorded**
Additional information:	**Took pills from fellow student at college- ECG noraml Dsicahrged with advice**

Yours sincerely,

GARY MANSON
EMERG MED STAFF GRADE

EMERGENCY DEPARTMENT
ROYAL ALEXANDRA HOSPITAL
CORSEBAR ROAD
PAISLEY
PA2 9PN

NHS
Greater Glasgow and Clyde

Dr ABID MAHMOOD
The Tannahill Centre
76 Blackstoun Road Paisley
PA3 1NT

Date: 30 Jan 2008

Dear Dr ABID MAHMOOD,

Re: JAMES WEIR, 34 Candren Road, PAISLEY, Renfrewshire, PA3 1DW
Date of Birth: 12/03/1989 CHI number: 1203893450

'our patient attended Royal Alexandra Hospital on the 30 Jan 2008.

The presenting complaint was:	**INTOXICATED**
Triage information:	**Not recorded**
The following investigations were carried out:	**U&E'S** **GLUCOSE** **LFT** **FULL BLOOD COUNT FBC**
The A&E diagnosis was:	**ALCOHOL RELATED PROBLEMS - ALCOHOL INTOXICATION**
The following treatment was given:	**None**
At the conclusion of treatment the patient was:	**Not specified**
Follow-up:	**Not recorded**
dditional information:	**None**

Yours sincerely,

NATALIE SOAVE
EMERG MED DOCTOR

EMERGENCY DEPARTMENT
ROYAL ALEXANDRA HOSPITAL
CORSEBAR ROAD
PAISLEY
PA2 9PN

NHS
Greater Glasgow and Clyde

Dr ABID MAHMOOD
The Tannahill Centre
76 Blackstoun Road Paisley
PA3 1NT

Date: 17 Jan 2008

Dear Dr ABID MAHMOOD,

Re: JAMES WEIR, 34 Candren Road, PAISLEY, Renfrewshire, PA3 1DW
Date of Birth: 12/03/1989 CHI number: 1203893450

our patient attended Royal Alexandra Hospital on the 17 Jan 2008.

The presenting complaint was:	**PAIN IN RIGHT SIDE**
Triage information:	**Not recorded**
The following investigations were carried out:	**U&E'S** **AMYLASE** **GLUCOSE** **LFT** **CRP** **CA** **FULL BLOOD COUNT FBC**
The A&E diagnosis was:	**GASTRO-INTESTINAL A5 - OTHER ABDOMINAL PAIN**
The following treatment was given:	**ADVICE GIVEN** **IV ACCESS**
At the conclusion of treatment the patient was:	**INCOMPLETE - PATIENT LEFT BEFORE BEING TREATED**
Follow-up:	**Not recorded**
Additional information:	**18yr male c/o R sided ab pain 3/7 severity 6/10. vomited x2 today Obs N, O/E ab SNT. Thank you**

Yours sincerely,

GOWRI PATHMANATHAN
EMERG MED DOCTOR

EMERGENCY DEPARTMENT
ROYAL ALEXANDRA HOSPITAL
CORSEBAR ROAD
PAISLEY
PA2 9PN

NHS
Greater Glasgow and Clyde

Dr ABDUL LATIF
THE TANNAHILL CENTRE
76 BLACKSTOON ROAD PAISLEY
PA3 1NT

Date: 14 Oct 2007

Dear Dr ABDUL LATIF ,

Re: JAMES WEIR, 34 CANDREN ROAD, PAISLEY, PA3 1DW
Date of Birth: 12/03/1989 CHI number: 1203893450

Your patient attended Royal Alexandra Hospital on the 13 Oct 2007.

The presenting complaint was:	**UNRESPONSIVE**
Triage information:	**WAS DRINKING ALCOHOL AND COLLAPSED VOMITED**
The following investigations were carried out:	**None**
The A&E diagnosis was:	**ALCOHOL RELATED PROBLEMS - ALCOHOL INTOXICATION**
The following treatment was given:	**IV CRYSTALLOID**
At the conclusion of treatment the patient was:	**Not specified**
Follow-up:	**Not recorded**
Additional information:	**None**

Yours sincerely,

RAVI PUNATI
DOCTOR

EMERGENCY DEPARTMENT
ROYAL ALEXANDRA HOSPITAL
CORSEBAR ROAD
PAISLEY
PA2 9PN

NHS
Greater Glasgow and Clyde

Dr ABID MAHMOOD
The Tannahill Centre
76 Blackstoun Road Paisley
PA3 1NT

Date: 07 Sep 2007

Dear Dr ABID MAHMOOD,

Re: JAMES WEIR, 34 Candren Road, PAISLEY, Renfrewshire, PA3 1DW
Date of Birth: 12/03/1989 CHI number: 1203893450

'our patient attended Royal Alexandra Hospital on the 07 Sep 2007.

The presenting complaint was:	**OVERDOSE**
Triage information:	**60 PARACETAMOL AT 15.00 , HIGH LETHALITY?**
The following investigations were carried out:	**U&E'S** **GLUCOSE** **CRP** **PARACETAMOL** **SALICYLATE** **FULL BLOOD COUNT FBC**
The A&E diagnosis was:	**SELF HARM - BY POISONING FROM DRUGS, MEDICATIONS OR OTHER SUBSTANCES**
The following treatment was given:	**None**
t the conclusion of treatment the patient was:	**Not specified**
Follow-up:	**Not recorded**
Additional information:	**Patient presented to A&E department after taking an overdose of paracetamol tablets. Admitted to medicine for futher trreatment and assessment including psychiatric review in am**

Yours sincerely,

KEITH D MCKILLOP
EMERG MED DOCTOR

EMERGENCY DEPARTMENT
ROYAL ALEXANDRA HOSPITAL
CORSEBAR ROAD
PAISLEY
PA2 9PN

NHS
Greater Glasgow and Clyde

Dr ABID MAHMOOD
The Tannahill Centre
76 Blackstoun Road Paisley
PA3 1NT

Date: 13 Aug 2007

Dear Dr ABID MAHMOOD,

Re: JAMES WEIR, 34 Candren Road, PAISLEY, Renfrewshire, PA3 1DW
Date of Birth: 12/03/1989 CHI number: 1203893450

our patient attended Royal Alexandra Hospital on the 13 Aug 2007.

The presenting complaint was:	**999 CALL TAKEN ALCOHOL AND PARACETAMOL**
Triage information:	**HIGH LETHALITY? SEE NURSING SHEET**
The following investigations were carried out:	**U&E'S** **ALCOHOL** **LFT** **GLUCOSE** **SALICYLATE** **PARACETAMOL** **FULL BLOOD COUNT FBC** **COAG SCREEN**
The A&E diagnosis was:	**SELF HARM - BY POISONING FROM DRUGS, MEDICATIONS OR OTHER SUBSTANCES**
The following treatment was given:	**None**
At the conclusion of treatment the patient was:	**Not specified**
Follow-up:	**Not recorded**
Additional information:	**None**

Yours sincerely,

PATRICK MACGOEY
PHYSICIAN-RECEIVING

EMERGENCY DEPARTMENT
ROYAL ALEXANDRA HOSPITAL
CORSEBAR ROAD
PAISLEY
PA2 9PN

NHS
Greater Glasgow and Clyde

Dr ABID MAHMOOD
The Tannahill Centre
76 Blackstoun Road Paisley
PA3 1NT

Date: 18 Jul 2007

Dear Dr ABID MAHMOOD,

Re: JAMES WEIR, 34 Candren Road, PAISLEY, Renfrewshire, PA3 1DW
Date of Birth: 12/03/1989 CHI number: 1203893450

our patient attended Royal Alexandra Hospital on the 18 Jul 2007.

The presenting complaint was:	**OVERDOSE**
Triage information:	**STATES TOOK 12 METRONIDAZOLE TABS ACCIDENTALLY THIS AM HAS SINCE BEEN DRINKING ALCOHOL AND IS NOW FEELING DIZZY, NAUSEATED AND TIPSY. STATES HAS HAD 1.5 HALF BOTTLES OF VODKA AND 2 CANS OF BEER , MODERATE LETHALITY?**
The following investigations were carried out:	**None**
The A&E diagnosis was:	**ALCOHOL RELATED PROBLEMS - ALCOHOL INTOXICATION**
The following treatment was given:	**None**
At the conclusion of treatment the patient was:	**Not specified**
Follow-up:	**Not recorded**
Additional information:	**Alleged OD of metronidazole this am for unclear reasons - says wanted to finish his prescription Subsequently had bottle-and-a-half of alcohol GCS 15 with normal obs Discharged**

Yours sincerely,

ALAN EXTON
CONSULTANT IN EMERGENCY MEDICINE

EMERGENCY DEPARTMENT
ROYAL ALEXANDRA HOSPITAL
CORSEBAR ROAD
PAISLEY
PA2 9PN

NHS
Greater Glasgow and Clyde

Dr ABID MAHMOOD
The Tannahill Centre
76 Blackstoun Road Paisley
PA3 1NT

Date: 11 Jul 2007

Dear Dr ABID MAHMOOD,

Re: JAMES WEIR, 34 Candren Road, PAISLEY, Renfrewshire, PA3 1DW
Date of Birth: 12/03/1989 CHI number: 1203893450

Your patient attended Royal Alexandra Hospital on the 11 Jul 2007.

The presenting complaint was:	**SWELLING TO FACE**
Triage information:	**Not recorded**
The following investigations were carried out:	**None**
The A&E diagnosis was:	**DENTAL PROBLEMS - DENTAL ABCESS**
The following treatment was given:	**PENICILLIN V 500MGS QDS** **CO-CODAMOL 30/500. 1-2 TABS, 4-6 HOURLY PRN (10 TABS SUPPLIED)**
At the conclusion of treatment the patient was:	**Not specified**
Follow-up:	**Not recorded**
Additional information:	**Upper frontal dental abscess Oral antibiotics given Advised to see dentist**

Yours sincerely,

GARY MANSON
EMERG MED STAFF GRADE

EMERGENCY DEPARTMENT
ROYAL ALEXANDRA HOSPITAL
CORSEBAR ROAD
PAISLEY
PA2 9PN

NHS
Greater Glasgow and Clyde

Dr ABID MAHMOOD
The Tannahill Centre
76 Blackstoun Road Paisley
PA3 1NT

Date: 08 May 2007

Dear Dr ABID MAHMOOD,

Re: JAMES WEIR, 34 Candren Road, PAISLEY, Renfrewshire, PA3 1DW
Date of Birth: 12/03/1989 CHI number: 1203893450

Your patient attended Royal Alexandra Hospital on the 08 May 2007.

The presenting complaint was:	**ABDO PAIN**
Triage information:	**ABDO PAIN SAW GP, PATIENT DECIDED TO ATTEND A AND E AS PAIN PERSISTS**
The following investigations were carried out:	**None**
The A&E diagnosis was:	**NONE ASSIGNED IN EDIS**
The following treatment was given:	**None**
At the conclusion of treatment the patient was:	**INCOMPLETE - PATIENT LEFT BEFORE ASSESSMENT COMPLETED**
Follow-up:	**Not recorded**
Additional information:	**None**

Yours sincerely,

STEPHEN HEARNS
CONSULTANT IN EMERGENCY MEDICINE

EMERGENCY DEPARTMENT
ROYAL ALEXANDRA HOSPITAL
CORSEBAR ROAD
PAISLEY
PA2 9PN

NHS
Greater Glasgow and Clyde

Dr ABID MAHMOOD
The Tannahill Centre
76 Blackstoun Road Paisley
PA3 1NT

Date: 14 Mar 2007

Dear Dr ABID MAHMOOD,

Re: JAMES WEIR, 34 Candren Road, PAISLEY, Renfrewshire, PA3 1DW
Date of Birth: 12/03/1989 CHI number: 1203893450

'our patient attended Royal Alexandra Hospital on the 14 Mar 2007.

The presenting complaint was:	**LACERATION TO LEFT ARM**
Triage information:	**Not recorded**
The following investigations were carried out:	**None**
The A&E diagnosis was:	**INCISED WOUND - UPPER ARM - LEFT**
The following treatment was given:	**INADINE DRESSING**
At the conclusion of treatment the patient was:	**Not specified**
Follow-up:	**Not recorded**
Additional information:	**None**

ours sincerely,

IAIN YOUNG
CONSULTANT IN EMERGENCY MEDICINE

EMERGENCY DEPARTMENT
ROYAL ALEXANDRA HOSPITAL
CORSEBAR ROAD
PAISLEY
PA2 9PN

NHS
Greater Glasgow and Clyde

Dr ABID MAHMOOD
The Tannahill Centre
76 Blackstoun Road Paisley
PA3 1NT

Date: 04 Oct 2006

Dear Dr ABID MAHMOOD,

Re: JAMES WEIR, 34 Candren Road, PAISLEY, Renfrewshire, PA3 1DW
Date of Birth: 12/03/1989 CHI number: 1203893450

Your patient attended Royal Alexandra Hospital on the 04 Oct 2006.

The presenting complaint was:	**ASSULTED TODAY EXAM**
Triage information:	**CALLED 1650 NO RESPONSE IN WAITING ROOM**
The following investigations were carried out:	**None**
The A&E diagnosis was:	**NONE ASSIGNED IN EDIS**
The following treatment was given:	**None**
At the conclusion of treatment the patient was:	**INCOMPLETE - PATIENT LEFT BEFORE ASSESSMENT COMPLETED**
Follow-up:	**Not recorded**
Additional information:	**None**

Yours sincerely,

NONE ASSIGNED IN EDIS
NONE ASSIGNED IN EDIS

Clinical letter - GP:

NHS
Greater Glasgow and Clyde

Royal Alexandra Hospital
Corsebar Road
Paisley
PA2 9PN
0141-887-9111

Dr. JC Sim
Quarryside Practice
Linden Medical Centre
25 Floors Street
Johnstone
PA5 8PZ

Main Switchboard:
Department: Medical Assessment Unit
Contact Tel: 0141-314-6850
Enquiries to: Tracey.Wright@ggc.scot.nhs.uk
Letter Date: 10/08/2017
Reference: LLC/AW/WS1945325
Dictated Date: 04/08/2017
Transcribed Date: 08/08/2017

Dear Dr Sim ,

James Weir; D.O.B: 12/03/1989; CHI: 1203893450
7D MACDOWALL STREET, Johnstone, Renfrewshire, PA5 8QJ

Final Discharge Letter following on from the Emergency Attendance Letter

Assessed and discharged: *24th July 2017*

Follow-up: *None*

Diagnosis(es): *Likely viral lower respiratory tract infection*

Past medical history: *Previous alcohol excess; Gastritis; Pancreatitis; Pericarditis; Inguinal hernia*

This 28 year old man had been on an outdoor course in the Highlands, and tells us that he had been walking up 'a really big mountain'.

He was complaining of central chest pain which was pleuritic. There was no sputum, and he was feeling generally unwell with muscle aches and nausea. He told us that he had a bottle of Buckfast for his breakfast that day. He smokes cigarettes and cannabis, but had not smoked cannabis for 4 weeks. He told us he felt like he had a chest infection.

Bloods were unremarkable, including a D-dimer, and chest x-ray was normal.

We thought he probably had a viral lower respiratory tract infection, and advised him to take plenty of fluids and simple analgesia.

No follow-up is in place.

Yours sincerely

DR LAURA CLARK

Consultant Gastroenterologist

Electronically Signed: Dr Laura-Louise Clark, Consultant

cc.

Clinical letter - Others:

NHS
Greater Glasgow and Clyde

Dr G Ray
Consultant Physician
Royal Alexandria Hospital
PAISLEY

Royal Alexandra Hospital
Corsebar Road
Paisley
PA2 9PN
Main Switchboard: 0141-887-9111

Department: Respiratory Medicine
Tel: 0141 314 7472
Enquiries to: hazel.giulianotti@ggc.scot.nhs.uk

Letter Date: 11/10/2013
Reference:
Dictated Date: 10/10/2013
Transcribed Date: 11/10/2013

Dear Gautam,

Name:	**Weir James**
CHI:	**1203893450**
DOB:	**12/03/1989**
Address:	**FLAT 2/1**
	94 PAISLEY RD
	Renfrew
	Renfrewshire
	PA4 8HD

I believe you run a first seizure clinic. May I refer this patient to your clinic. I have enclosed a copy of my recent discharge summary for your information.

Yours sincerely

Dr Yi Ling

Consultant Respiratory Physician

Electronically Signed: Dr Yi Ling, Consultant

cc. Dr Sunderland, The Health Centre, 103 Paisley Road, Renfrew

Clinic Letter

NHS
Greater Glasgow and Clyde

Royal Alexandra Hospital
Corsebar Road
Paisley
PA2 9PN
0141-887-9111

Dr. EC Renwick
Quarryside Practice
Linden Medical Centre
25 Floors Street
Johnstone
PA5 8PZ

Main Switchboard: 0141-887-9111
Department: Orthopaedics
Contact Tel: 0141 314 7195
Enquiries to: marie.patton@ggc.scot.nhs.uk
Letter Date: 16/11/2015
Reference: Mr Rashid Abu-rajab /JC
Dictated Date: 16/11/2015
Transcribed Date: 16/11/2015

Dear Dr. EC Renwick,

James Weir; D.O.B: 12 Mar 1989; CHI: 1203893450
17D MACDOWALL STREET, Johnstone, Renfrewshire, PA5 8QJ

Attendance: Specialty - Orthopaedics ; Clinic - RARBAOR1-MR ABU RAJAB FRACTURE MON AM
Date and Time of Appointment - 16/11/2015 09:20

Follow Up: Discharged

Clinical Comments:
Diagnosis: Fracture base of 4th metacarpal
Date of Injury: 03.11.15

This gentleman was seen today after being recalled by A&E. He punched a wall and was seen in A&E then he was thought to have no bony injury. The x-ray report came back showing a fracture.

On review today he is moving the hand quite well. He has noticed some pain in the middle of the hand and he wondered why it was going on for so long.

X-rays taken today are satisfactory with the fracture still barely visible but not gross displacement.

I have reassured him that this will hopfully settle with time and he has been discharged from the clinic. I advised him to return if there are any problems.

Yours sincerely

Mr Rashid Abu-rajab
Consultant Orthopaedic Surgeon

Electronically Signed: Mr Rashid Abu-rajab , Consultant

cc.

Final Discharge Letter

NHS
Greater Glasgow and Clyde

Royal Alexandra Hospital
Corsebar Road
Paisley
PA2 9PN
0141-887-9111

Dr. JC Sim
Quarryside Medical Practice
Linden Medical Centre
25 Floors Street
Johnstone
PA5 8PZ

Main Switchboard:	
Department:	Respiratory Unit
Contact Tel:	0141 314 6859 - Fiona
Enquiries to:	fiona.mccormick@ggc.scot.nhs.uk
Letter Date:	19/06/2020
Reference:	JHG/FMcC
Dictated Date:	17/06/2020
Transcribed Date:	19/06/2020

Dear Dr. JC Sim,

James Weir; D.O.B: 12/03/1989; CHI: 1203893450
27D MACDOWALL STREET, Johnstone, Renfrewshire, PA5 8QJ

Admission: Specialty - General Medicine; Ward - RAH AMU Ward 2 General Medicine
Consultant - Dr Jane Gravil ; Date of Admission - 10/06/2020
Date of Discharge - 11/06/2020; Discharged to -

Clinical Comments:
DIAGNOSES :

1. **ALCOHOL INTOXICATION**
2. **VOMITING WITH MINOR HAEMATEMESIS**

This gentleman took a rather aggressive irregular discharge. He had tried to stop drinking and then omited for three days in a row. There was a small amount of blood in one of the vomits and he possibly had had a seizure the night before admission. He has a background of alcohol related seizures.

When I saw him he was quite lucid, a bit tearful and was on regular Diazepam. He took irregular discharge a short time later.

Yours sincerely

JANE H GRAVIL

CONSULTANT IN RESPIRATORY MEDICINE

Electronically Signed: Dr Jane Gravil , Consultant

cc.

Final Discharge Letter

NHS
Greater Glasgow and Clyde

Royal Alexandra Hospital
Corsebar Road
Paisley
PA2 9PN
Main Switchboard: 0141-887-9111
Department: AMU
Contact Tel: 0141 314 9776
Enquiries to:

Dr. EC Renwick
Quarryside Practice
Linden Medical Centre
25 Floors Street
Johnstone
PA5 8PZ

Letter Date: 14/08/2015
Reference: ZM/AW/898076
Dictated Date: 12/08/2015
Transcribed Date: 13/08/2015

Dear Dr. EC Renwick,

James Weir; D.O.B: 12/03/1989; CHI: 1203893450
27D MACDOWALL STREET, Johnstone, Renfrewshire, PA5 8QJ

Admission: Specialty - General Medicine; Ward - RAH AMU Ward 2 General Medicine
Consultant - Dr Zia Mustafa Mohammed; Date of Admission - 11/08/2015
Date of Discharge - 11/08/2015; Discharged to - Private Residence - no additional detail added

Diagnosis:
Acute Alcohol intoxication (ICD10: F10.0)

Clinical Comments:
James apparently absconded even before a consultant review and seems to have been admitted with a collapse and possible pseudo-seizures.

Many thanks. Yours sincerely
DR ZIA MUSTAFA
Consultant Physician and Gastroenterologist

Electronically Signed: Dr Zia Mustafa, Doctor

cc.

Final Discharge Letter

NHS
Greater Glasgow and Clyde

Royal Alexandra Hospital
Corsebar Road
Paisley
PA2 9PN
Main Switchboard: 0141-887-9111
Department: Acute Medical Unit
Contact Tel: 0141 314 6980
Enquiries to: Joan.McCredie@ggc.scot.nhs.uk

Dr. DA Foster
Dr D A Foster & Dr A E Crawford
The Health Centre
20 Duncan Street
Greenock
PA15 4LY

Letter Date: 24/03/2015
Reference: IK/JMC
Dictated Date: 10/03/2015
Transcribed Date: 20/03/2015

Dear Dr. DA Foster,

James Weir; D.O.B: 12/03/1989; CHI: 1203893450
Flat D, 27 MacDowall Street, Johnstone, Renfrewshire, PA5 8QJ

Admission: Specialty - General Medicine; Ward - RAH 19 - General Surgery
Consultant - Dr Iain Keith; Date of Admission - 01/03/2015
Date of Discharge - 02/03/2015; Discharged to - No fixed abode

Follow Up: endoscopy

Clinical Comments:

DIAGNOSES: 1) Upper GI bleed, Blatchford score 0. For outpatient endoscopy.
2) Suicidal ideation. Reviewed by psychiatry - for crisis numbers and social work - referral done by Dr Oto.

This 25 year old gentleman had an episode of haematemesis. He was drinking alcohol heavily and noted vomiting up some blood. His Blatchford score was 0. Haemoglobin was 144, urea was 4.8. He was haemodynamically stable. He said he had suicidal ideation.

Certainly from a medical point of view he was fit for discharge. He was reviewed by psychiatry a day later and had no further suicidal ideation and was given crisis numbers and discharged.

Yours sincerely

Dr Iain Keith
Consultant Physician in Acute Medicine

Electronically Signed: Dr Iain Keith, Consultant

cc.

Final Discharge Letter

NHS
Greater Glasgow and Clyde

Royal Alexandra Hospital
Corsebar Road
Paisley
PA2 9PN
Main Switchboard: 0141-887-9111
Department: AMU
Contact Tel: 0141 314 9776
Enquiries to:

Dr. CJ Johnstone
The Barony Practice
Northcroft Medical Centre
Paisley
PA3 4AD

Letter Date: 23/10/2014
Reference: GN/AW
Dictated Date: 21/10/2014
Transcribed Date: 22/10/2014

Dear Dr. CJ Johnstone,

James Weir; D.O.B: 12/03/1989; CHI: 1203893450
69C DUNDONALD ROAD, Paisley, Renfrewshire, PA3 4NB

Admission: Specialty - General Medicine; Ward - RAHMAU - Medical Assessment Unit
Consultant - Dr Graham Naismith; Date of Admission - 22/09/2014
Date of Discharge - 22/09/2014; Discharged to - Private Residence - living with relatives or friends

Follow Up: None

Clinical Comments:
Diagnoses:

1. **Suggestion of alcohol withdrawal but well at the time of consultant review**
2. **Previous alcohol withdrawal symptoms and alcohol excess**
3. **Smoker - 10 cigarettes per day**
4. **Regular heroin, cocaine and MDMA use**

This 25 year old man was admitted with symptoms of tremor, nausea and vomiting. He is known to drink alcohol to excess but claimed to have not taken anything for 10 days.

He was asymptomatic following his admission and keen for discharge on my review. He wished to be re-admitted for alcohol detoxification and claimed he would make his own arrangements for this. We discharged him without plans for further follow-up.

Yours sincerely
DR GRAHAM NAISMITH
Consultant Physician and Gastroenterologist

Electronically Signed: Dr Graham Naismith, Consultant

cc.

Final Discharge Letter

NHS
Greater Glasgow and Clyde

Royal Alexandra Hospital
Corsebar Road
Paisley
PA2 9PN

Main Switchboard: 0141-887-9111
Department: Acute Medical Unit
Contact Tel: 0141 314 9777
Enquiries to: Theresa.Porter2@ggc.scot.nhs.uk
Letter Date: 19/09/2014
Reference: GR/TP/309548
Dictated Date: 10/09/2014
Transcribed Date: 15/09/2014

Dr. A Sunderland
Kingsinch Medical Practice
Renfrew Health Centre
10 Ferry Road
Renfrew
PA4 8RU

Dear Dr. A Sunderland,

James Weir; D.O.B: 12/03/1989; CHI: 1203893450
3B MITCHELL AVENUE, Renfrew, Renfrewshire, PA4 8DT

Admission: Specialty - General Medicine; Ward - RAH AMU -Ward 2 General Medicine
Consultant - Dr Gautam Ray; Date of Admission - 14/08/2014
Date of Discharge - 14/08/2014; Discharged to - Private Residence - no additional detail added

Follow Up: Outpatient Upper GI endoscopy; with the De-addiction team in the community

Clinical Comments:

Diagnoses: 1. Alcohol Excess 2. Heroin Abuse 3. Previous Alcohol Related Seizure 4. Low Risk Upper GI Haemorrhage Secondary to Retching

Medications on Discharge: As Per the Immediate Discharge Letter

I saw this 25 year old gentleman who was released from Police custody on the day of admission. He came in with a history of abdominal pain, vomitting of a small amount of fresh blood on a background of alcohol excess and heroin abuse. He drinks 13 units of alcohol per day, smokes 10-15 cigarettes per day and uses heroin daily. He is usually fit and well otherwise, apart from having previous alcohol related seizures and alcohol withdrawals.

After admission he was tired and there were no signs of any alcohol or heroin withdrawal. He was eating and drinking. He had no further upper GI bleeds and no history of any malena. His chest x-ray and 12 lead ECG were normal. He possibly had some low risk upper GI haemorrhage due to retching. He was referred to de-addiction team but refused any help. He is apparently due to be seen by the de-addiction team in the community next week. We allowed him him with an outpatient upper GI endoscopy.

Yours sincerely

Dr Gautam Ray

Consultant Physician in Acute Medicine

Electronically Signed: Dr Gautam Ray, Consultant

cc.

Final Discharge Letter

NHS Greater Glasgow and Clyde

Dr. CJ Johnstone
The Barony Practice
Northcroft Medical Centre
Paisley
PA3 4AD

Royal Alexandra Hospital
Corsebar Road
Paisley
PA2 9PN

Main Switchboard: 0141-887-9111

Date of Completion: 07/05/2014

Email Enquiries to: Debra McGlone
Contact Tel Details: 0141 314 9775

Dictated: 23/04/2014
Transcribed: 06/05/2014

Dear Dr. CJ Johnstone,

Patient

Name:	Weir James
CHI:	1203893450
DOB:	12/03/1989
Address:	1/7 17 ABERCORN STREET
	Paisley
	PA3 4AA

Admission

Admitted:	26/03/2014 17:54
Discharged:	31/03/2014 15:00
Admission Type:	In Patient
Discharge to:	Private Residence - living with relatives or friends
Consultant:	Dr Claire Harrow
Specialty:	General Medicine

Reason for Admission: Admission for treatment - Where the patient is expected to be treated for a diagnosed condition not otherwise specified

Clinical Comments:
Diagnosis:

Alcohol excess

This gentleman was admitted to the medical ward, vomiting and complaining of abdominal pain. He had been abstinent from alcohol for 48 hours.

Clinical examination was unremarkable as were his routine bloods.

The clinical impression was that of alcohol withdrawal.

He was treated with intravenous vitamins and Diazepam. He continued to complain of abdominal pain, although amylase was normal and he was hemodynamically normal.

He was fit for discharge on 31 March 2014 with no plans for follow up. He was reviewed by the alcohol services as an in-patient. We have no plans for follow up.

Yours sincerely

Dr Claire Harrow

Consultant Physician

Follow-up arranged: nil

Electronically Signed: Dr Claire Harrow, Consultant

cc.

Final Discharge Letter

NHS Greater Glasgow and Clyde

Dr. CJ Johnstone
The Barony Practice
Northcroft Medical Centre
Paisley
PA3 4AD

Royal Alexandra Hospital
Corsebar Road
Paisley
PA2 9PN

Main Switchboard: 0141-887-9111

Date of Completion: 24/01/2014

Email Enquiries to:
Contact Tel Details: 0141 314 6134

Dictated: 13/01/2014
Transcribed: 21/01/2014

Dear Dr. CJ Johnstone,

Patient

Name:	Weir James
CHI:	1203893450
DOB:	12/03/1989
Address:	1/7 17 ABERCORN STREET
	Paisley
	PA3 4AA

Admission

Admitted:	02/01/2014 20:48
Discharged:	03/01/2014 14:44
Admission Type:	In Patient
Discharge to:	Private Residence - no additional detail added
Consultant:	Dr Martin Perry
Specialty:	General Medicine

Reason for Admission: Admission for treatment - Where the patient is expected to be treated for a diagnosed condition not otherwise specified

Diagnosis

Diagnosis	Code
Acute Alcohol intoxication - Seizures	F10.06

Clinical Comments:

Diagnosis: Seizure

Background: Epilepsy and alcohol related seizures

This 24 year old was admitted following a further seizure. He has an outpatient neurology appointment pending imminently and experienced a further grand mal event. He has already informed the DVLA.

His working evironment is with Amazon and he denies working at any heights. He also denied taking much alcohol.

Examination findings were unremarkable with the exception of dilated pupils. Cardiovascular and respiratory examination normal. Chest x-ray, ECG and bloods all unremarkable.

I suspect it is likely that he does have epilepsy. His alcohol intake is actually minimal. He has neurological follow-up and has already had a previous CT scan.

I have not arranged any additional investigations but await the expert advice of the neurologists. No changes were made to medications.

Yours sincerely

DR MARTIN PERRY

Consultant Physician and Rheumatologist

Follow-up arranged: With neurology at SGH

Electronically Signed: Dr Martin Perry, Consultant

cc. none

Final Discharge Letter

NHS
Greater Glasgow and Clyde

Dr. A Sunderland
Kingsinch Medical Practice
Renfrew Health Centre
10 Ferry Road
Renfrew
PA4 8RU

Royal Alexandra Hospital
Corsebar Road
Paisley
PA2 9PN

Main Switchboard: 0141-887-9111

Date of Completion: 07/01/2014

Email Enquiries to: Patricia.Berrie@ggc.scot.nhs.uk
Contact Tel Details: 0141 314 7075

Dictated: 24/12/2013
Transcribed: 24/12/2013

Dear Dr. A Sunderland,

Patient

Name: Weir James
CHI: 1203893450
DOB: 12/03/1989
Address: 17 Abercorn Street
Paisley
PA3 4AA

Admission

Admitted: 12/12/2013 23:47
Discharged: 18/12/2013 13:58
Admission Type: In Patient
Discharge to: Private Residence - no additional detail added
Consultant: Mr Mark Vella
Specialty: General Surgery

Reason for Admission: Acute Admission no additional detail added

Diagnosis

Diagnosis	Code
Abdominal pain - Unspecified	R10.4

Clinical Comments:

Admitted: 12.12.13

Discharged: 18.12.13

Diagnosis: Gastritis

Follow up:- Outpatient clinic appointment 3 months

This 24-year old was admitted with a 4 weeks history of left sided abdominal pain. The initial concern was that this may represent ureteric colic and he therefore underwent a CT KUB. This revealed faecal loading and some very minor inflammatory change around the upper ureter but his MSU was negative and he was reviewed by the Urologists, they did not feel this represented a significant finding. A gastroscopy was conducted and this revealed gastritis and bile reflux into the pylorus. A CLO test was negative. James was given a trial of PPI and Sucralfate and discharge with a plan to follow up in the clinic in 3 months time.

Yours sincerely

Mr Chris Ray
Surgical ST6

Follow-up arranged: Mr Vella clinic 3/12

lectronically Signed: Dr Christopher Ray, Doctor

cc.

Final Discharge Letter

NHS Greater Glasgow and Clyde

Dr. A Sunderland
The Health Centre
103 Paisley Road
Renfrew
PA4 8LH

Royal Alexandra Hospital
Corsebar Road
Paisley
PA2 9PN

Main Switchboard: 0141-887-9111

Date of Completion: 11/10/2013

Email Enquiries to: hazel.giulianotti@ggc.scot.nhs.uk
Contact Tel Details: 0141 314 7472

Dictated: 10/10/2013
Transcribed: 11/10/2013

Dear Dr. A Sunderland,

Patient

Name:	Weir James
CHI:	1203893450
DOB:	12/03/1989
Address:	FLAT 2/1
	Renfrew
	PA4 8HD

Admission

Admitted:	05/10/2013 04:56
Discharged:	06/10/2013 15:40
Admission Type:	In Patient
Discharge to:	Private Residence - living alone
Consultant:	Dr Yi Ling
Specialty:	General Medicine

Reason for Admission: Admission for treatment - Where the patient is expected to be treated for a diagnosed condition not otherwise specified

Clinical Comments:

Reason for admission: possible alcohol related seizure

Other diagnosis: excess alcohol intake, previous overdose

This 24 year old lives in a homeless shelter. He felt anxious on the day of admission. His friend offered him 3 blue tablets. Soon after ingestion of these unknown tablets he felt odd, was

hallucinating and had pins and needles all over his body. He then had a seizure that was witnessed by his friend. He also drank a litre of cider in the same evening an hour before he took those tablets. His blood results were all unremarkable.

By the time he was seen by the medical team he was back to his normal self. He had no further seizure activity in hospital. He was started on IV Pabrinex. He is already known to the alcohol liaison team. CT head was normal. He was advised he should not drive for at least 6 onths after his first onset seizure and he is aware he needs to inform the DVLA.

Follow up – referral to first seizure clinic.

Medication – as per immediate discharge summary dated 06/10/13.

Yours sincerely

Dr Yi Ling

Consultant Respiratory Physician

Electronically Signed: Dr Yi Ling, Consultant

cc. Dr Gautam Ray, Consultant Physician, RAH

Immediate Discharge Letter

NHS Greater Glasgow and Clyde

Highly Sensitive: No
Consent for Sharing Withheld: No

JULIET SIMQuarryside Medical Practice,Linden Medical Centre,25 Floors Street, Johnstone, PA5 8PZ

Royal Alexandra Hospital,Corsebar Road,Paisley,PA2 9PN
Main Switchboard: 0141 8879111
Date of Completion: 13-Jun-2020

Dear JULIET SIM,

Name	CHI	DoB	Address
James Weir	**1203893450**	**12-Mar-1989**	**27D MACDOWALL STREET, Johnstone, Renfrewshire, PA5 8QJ**

Admitted	Type	Discharged	Destination
10-Jun-2020 18:47	IP	11-Jun-2020	

Specialty	Consultant	Ward	Telephone
General Medicine	Gravil	RAH AMU Ward 2 General Medicine	0141 8879111

Primary Diagnosis
There is no data to display.

Secondary Diagnosis
There is no data to display.

Significant Operations / Procedures:
There is no data to display.

Last Discharge Review: Mairi Laing (Mairi Laing - FY1) on 13 Jun 2020 13:14

Discharge Medication:

Active Drug Name	Route	Dose	Disp	Reason	Further Details	ECS	Since Admission
Mirtazapine 15mg tablets	oral	ONE TO BE TAKEN AT NIGHT,	No	Patient left before supplied		Y	

"Added" means this medicine was added to the Clinical Portal record after admission. It does not necessarily mean this medicine was started by the hospital.

Dispensing Comments
There is no data to display.

Withheld Medication:

Date	Withheld Drug Name	Route	Dose	Note	Withheld Reason
There is no data to display.					

Stopped Medication:

Date	Stopped Drug Name	Route	Dose	Note	Stopped Reason
There is no data to display.					

Reason for Admission and Presenting Complaints	Admission Category
No data available	No data available

Clinical Comments:	
	Dear doctor, Mr Weir was admitted to the RAH on 10/06/20 in alcohol withdrawal with a history of vomiting after stopping drinking 1 day previous. He also described some haematemesis. Haemoglobin was 146. Impression: Alcohol withdrawal Mr Weir was admitted for GMAWS, Pabrinex and IV fluids. Mr Weir wished to discharge against medical advice and left the ward. No change to regular medications.

	Kind regards, Mairi Laing FY1 AMU
Follow Up:	No .
Results Awaited:	No
Pharmacist Comments:	
Final Discharge Letter to Follow:	Yes

Yours sincerely,

Mairi Laing

Prescription Review
Checked by: Mairi Laing (FY1)
Discharged by: Mairi Laing (FY1)

Weir James CHI: 1203893450

Immediate Discharge Letter

NHS Greater Glasgow and Clyde

Highly Sensitive: No Consent for Sharing Withheld: No

Royal Alexandra Hospital
Corsebar Road
Paisley
PA2 9PN
Main Switchboard: 0141-887-9111
Date of Completion: 11/08/2015

Dr. EC Renwick
Quarryside Practice
Linden Medical Centre
25 Floors Street
Johnstone
PA5 8PZ

Dear Dr EC Renwick,

Name	CHI	DoB	Address
James Weir	1203893450	12/03/1989	27D MACDOWALL STREET Johnstone PA5 8QJ

Admitted	Type	Discharged	Destination
11/08/2015 02:16	In Patient	11/08/2015	

Specialty	Consultant	Ward	Telephone
General Medicine	Dr Zia Mustafa Mohammed	RAH AMU Ward 2 General Medicine	0141-314-9756/9763

Reason for Admission and Presenting Complaints	Admission Category
	Admission for treatment - Where the patient is expected to be treated for a diagnosed condition not otherwise specified

Diagnosis	Site	Side
Acute Alcohol intoxication (ICD10: F10.0)		

Date	Procedures/Interventions/Operations

Clinical Comments: Dear Doctor,

This 26 year old man presented to A and E with a witnessed collpase and possible pseudoseizure. There was no head injury, seizure activity, tongue biting or urinary incontinence. He subsequently had an episode of unresponsiveness with GCS of 3, though this was short-lived.

Mr Weir remembered being with a friend to celebrate a new job over breakfast. He thought that the friend 'gave him something' and the next thing he remembered, he was in resus and feeling unwell.

He had a further collapse in the corridor. He was unrousable and had soe psuedoseizure activity. Afterwards he did not engage nd his GCS was 15/15 with the ijmpression that this was due to alcohol intoxicaton. On 11th

~August he had left the hospital. He did not express suicidal ideation but police were contacted and they will search for him. On discharge, he had two IV cannulae. He had been referred to alcohol addictions and will check if he will have any community psychiatric input.

Kind regards,
Sukhmeet Singh (FY1)

Treatments: None recorded.

Follow-up arranged: Currenly being searched for by police.

Planned Outpatient Investigations: nil

Final Discharge letter to follow: Yes

Medication Info:

Allergies: Penicillins

Height: cm **Weight:** kg

Discharge Medication:

Medicine	Route	Dose	UOM	Frequency	Duration	Pharmacy Comment
Omeprazole Capsules	Oral	20	mg	ONCE a Day	No duration defined	
Venlafaxine Tablets	Oral	75	mg	ONCE a Day	No duration defined	

Discontinued Medication:

Drug Name	Dose	UOM	Reason

Yours sincerely,
Dr Sukhmeet Singh
Doctor

Prescription Review
Medications Reviewed by Pharmacist: ,
Dispensed Medications Checked by Pharmacy: ,
Nurse discharging patient: Teresa Porter,

Weir James CHI: 1203893450

Immediate Discharge Letter

NHS Greater Glasgow and Clyde

Highly Sensitive: No Consent for Sharing Withheld: No

Royal Alexandra Hospital
Corsebar Road
Paisley
PA2 9PN
Main Switchboard: 0141-887-9111
Date of Completion: 25/04/2015

Dr. EC Renwick
Quarryside Practice
Linden Medical Centre
25 Floors Street
Johnstone
PA5 8PZ

Dear Dr EC Renwick,

Name	CHI	DoB	Address
James Weir	1203893450	12/03/1989	27D MACDOWALL STREET Johnstone PA5 8QJ

Admitted	Type	Discharged	Destination
24/04/2015 13:37	In Patient	25/04/2015	

Specialty	Consultant	Ward	Telephone
General Surgery	Mr Mark Vella	RAH 26 - General Surgery	0141 314 7026

Reason for Admission and Presenting Complaints	Admission Category
	Admission for treatment - Where the patient is expected to be treated for a diagnosed condition not otherwise specified

Diagnosis	Site	Side

Date	Procedures/Interventions/Operations

Clinical Comments: 26 year old gentleman admitted with subprabuic pain. Bloods normal. Nil significant on examination other than some suprapubic tenderness. Urine dipstick suggestive of UTI. Fit for discharge to complete course of oral antibiotics and analgesia.
Many Thanks

Treatments: None recorded.

Follow-up arranged: nil

Planned Outpatient Investigations: nil

Final Discharge letter to follow: yes

Medication Info:

Allergies: Penicillins
Height: cm **Weight:** kg

Discharge Medication:

Medicine	Route	Dose	UOM	Frequency	Duration	Pharmacy Comment
Co-codamol 30/500 Tablets	Oral	2	tablet(s)	FOUR Times a Day	No duration defined	1OP
Diclofenac Sodium E/C Tablets	Oral	50	mg	THREE Times a Day	No duration defined	28
Lactulose Solution	Oral	10	mL	Every morning and night	No duration defined	1OP
Trimethoprim Tablets	Oral	200	mg	Every morning and night	6 Days	12

Discontinued Medication:

Drug Name	Dose	UOM	Reason

Yours sincerely,
Dr Daniel Pugh
Doctor

Prescription Review
Medications Reviewed by Pharmacist: Daniel Pugh, Doctor
Dispensed Medications Checked by Pharmacy: Jonathan Yates, Pharmacist
Nurse discharging patient: Sonny Morrison, Nurse

Weir James CHI: 1203893450

Immediate Discharge Letter

Highly Sensitive: No Consent for Sharing Withheld: No

NHS Greater Glasgow and Clyde

Royal Alexandra Hospital
Corsebar Road
Paisley
PA2 9PN
Main Switchboard: 0141-887-9111
Date of Completion: 03/03/2015

Dr. DA Foster
Dr D A Foster & Dr A E Crawford
The Health Centre
20 Duncan Street
Greenock
PA15 4LY

Dear Dr DA Foster,

Name	CHI	DoB	Address
James Weir	1203893450	12/03/1989	Flat D Johnstone PA5 8QJ

Admitted	Type	Discharged	Destination
01/03/2015 14:59	In Patient	02/03/2015	

Specialty	Consultant	Ward	Telephone
General Medicine	Dr Iain Keith	RAH 19 - General Surgery	0141 314 7019

Reason for Admission and Presenting Complaints	Admission Category
	Admission for treatment - Where the patient is expected to be treated for a diagnosed condition not otherwise specified

Diagnosis	Site	Side

Date	Procedures/Interventions/Operations

Clinical Comments: Mr Weir was admitted with haematemesis on the background of alcohol excess. He reported about 6-7 episodes of haematemeis but no malaena. We treated him for alcohol withdrawal using GMAWs. His admission bloods showed an normal Hb and he was haemodynamically stable. He was reviewed by psych liason who will get in contact with his social work team. He is now deemed fit for discharge and is to have an outpatient upper GI endoscopy.
Many thanks.

Treatments: None recorded.

Follow-up arranged: none

Planned Outpatient Investigations: upper GI endoscopy

Final Discharge letter to follow: yes

Medication Info:

Allergies: Penicillins

Height: cm **Weight:** kg

Discharge Medication:

Medicine	Route	Dose	UOM	Frequency	Duration	Pharmacy Comment
Chlordiazepoxide Capsules	Oral	20	mg	THREE Times a Day	No duration defined	At home (10th Feb)
Omeprazole Capsules	Oral	40	mg	ONCE a Day	No duration defined	
Thiamine Hydrochloride Tablets	Oral	100	mg	THREE Times a Day	No duration defined	At home (issued 10th Feb)

Medication Comment: Patient irregular discharged from ward before script could be done. Omeprazole is new. FR

Discontinued Medication:

Drug Name	Dose	UOM	Reason

Yours sincerely,
Dr Sylvia Kamya
Doctor

Prescription Review
Medications Reviewed by Pharmacist: ,
Dispensed Medications Checked by Pharmacy: ,
Nurse discharging patient: Helen Watson2,

Weir James CHI: 1203893450

Immediate Discharge Letter

NHS Greater Glasgow and Clyde

Highly Sensitive: No Consent for Sharing Withheld: No

Royal Alexandra Hospital
Corsebar Road
Paisley
PA2 9PN
Main Switchboard: 0141-887-9111
Date of Completion: 23/09/2014

Dr. A Sunderland
Kingsinch Medical Practice
Renfrew Health Centre
10 Ferry Road
Renfrew
PA4 8RU

Dear Dr A Sunderland,

Name	CHI	DoB	Address
James Weir	1203893450	12/03/1989	3B MITCHELL AVENUE Renfrew PA4 8DT

Admitted	Type	Discharged	Destination
22/09/2014 16:41	In Patient	22/09/2014	

Specialty	Consultant	Ward	Telephone
General Medicine	Dr Graham Naismith	RAHMAU - Medical Assessment Unit	0141 314 9755

Reason for Admission and Presenting Complaints	Admission Category
	Admission for treatment - Where the patient is expected to be treated for a diagnosed condition not otherwise specified

Diagnosis	Site	Side

Date	Procedures/Interventions/Operations

Clinical Comments: Mr Weir is a 25 year gentleman who was seen at the MAU on 22/09/14 with a 1 day history of tremors, nausea and vomitting. he had been drinking excessively for weeks and had stopped 10 days prior to admission. He had also been taking a mixture of illicit drugs for the last few days. He was unable to keep any fluids on the morning of admission. On admission his observations were normal and physical examinations were unremarkable. Bloods were normal, as were ECG and CXR. He was keen to go home and has mentioned he will make arrangements for 'rehab' post-discharge.

Treatments: None recorded.

Follow-up arranged: n

Planned Outpatient Investigations: n

Final Discharge letter to follow: n

Medication Info:

Allergies: Penicillins

Height: cm **Weight:** kg

Discharge Medication:

Medicine	Route	Dose	UOM	Frequency	Duration	Pharmacy Comment

Discontinued Medication:

Drug Name	Dose	UOM	Reason

Yours sincerely,
Doctor Dhinakaran Anbalagan
Doctor

rescription Review

Medications Reviewed by Pharmacist: ,
Dispensed Medications Checked by Pharmacy: ,
Nurse discharging patient: Dhinakaran Anbalagan, Doctor

Weir James CHI: 1203893450

Immediate Discharge Letter

NHS
Greater Glasgow and Clyde

Highly Sensitive: No Consent for Sharing Withheld: No

Royal Alexandra Hospital
Corsebar Road
Paisley
PA2 9PN
Main Switchboard: 0141-887-9111
Date of Completion: 05/09/2014

Dr. A Sunderland
Kingsinch Medical Practice
Renfrew Health Centre
10 Ferry Road
Renfrew
PA4 8RU

Dear Dr A Sunderland,

Name	CHI	DoB	Address
James Weir	1203893450	12/03/1989	3B MITCHELL AVENUE Renfrew PA4 8DT

Admitted	Type	Discharged	Destination
14/08/2014 03:31	In Patient	14/08/2014	

Specialty	Consultant	Ward	Telephone
General Medicine	Dr Gautam Ray	RAH AMU -Ward 2 General Medicine	0141-314-9756/9763

Reason for Admission and Presenting Complaints	Admission Category
	Acute Admission no additional detail added

Diagnosis	Site	Side

Date	Procedures/Interventions/Operations

Clinical Comments:

Dear Dr,
This 25 year old patient was admitted to the acute medical unit of the RAH on 13/08/14 following an episode of chest pain. He was thought to be intoxicated at the time, and was monitored overnight for signs of withdrawal. The following morning, he was assessed by alcohol liaison, but refused any help from them. He was thought to be of risk for an UGI bleed, secondary to his alcohol excess, and an OGD as an outpatient has been arranged for him.
He has now been discharged home.

Kind regards,
Nora Gonzalez, FY1

Treatments: None recorded.

Follow-up arranged: none

Planned Outpatient Investigations: OGD

Final Discharge letter to follow: yes

Medication Info:

Allergies: Penicillins

Height: cm **Weight:** kg

Discharge Medication:

Medicine	Route	Dose	UOM	Frequency	Duration	Pharmacy Comment

Discontinued Medication:

Drug Name	Dose	UOM	Reason

Yours sincerely,
Dr Nora Gonzalez
Doctor

Prescription Review
Medications Reviewed by Pharmacist: ,
Dispensed Medications Checked by Pharmacy: ,
Nurse discharging patient: Nora Gonzalez, Doctor

Weir James CHI: 1203893450

Immediate Discharge Letter

NHS Greater Glasgow and Clyde

Highly Sensitive: No Consent for Sharing Withheld: No

Royal Alexandra Hospital
Corsebar Road
Paisley
PA2 9PN
Main Switchboard: 0141-887-9111
Date of Completion: 31/03/2014

Dr. CJ Johnstone
The Barony Practice
Northcroft Medical Centre
Paisley
PA3 4AD

Dear Dr CJ Johnstone,

Name	CHI	DoB	Address
James Weir	1203893450	12/03/1989	1/7 17 ABERCORN STREET Paisley PA3 4AA

Admitted	Type	Discharged	Destination
26/03/2014 17:54	In Patient	31/03/2014	Private Residence - no additional detail added

Specialty	Consultant	Ward	Telephone
General Medicine	Dr Christopher Smith	RAH 28 - Urology	0141 314 7028

Reason for Admission and Presenting Complaints	Admission Category
Alcohol excess >pain	Admission for treatment - Where the patient is expected to be treated for a diagnosed condition not otherwise specified

Diagnosis	Site	Side

Date	Procedures/Interventions/Operations

Clinical Comments: presented with lower abdominal pain, following a episode of high alcohol intake.
Otherwise well, normal blood tests
Pain in the abdomen was belived to be related to alochol excess. He says he will try and cut down. if pain persists to attend his GP.
He is fit for discharge, he will be seen by the alcohol liasion team after discharge as unable to visit in ward.

Treatments: paracetamol and tramadol with iv Pabrinex for 3 days.

Follow-up arranged: nilo

Planned Outpatient Investigations: nil

Final Discharge letter to follow: yes

Medication Info:

Allergies:

Height: cm **Weight:** kg

Discharge Medication:

Medicine	Route	Dose	UOM	Frequency	Duration	Pharmacy Comment
Citalopram Tablets	Oral	20	mg	In the Morning	No duration defined	5
Omeprazole Capsules	Oral	20	mg	In the Morning	No duration defined	28
Paracetamol Tablets	Oral	1000	mg	As Required	No duration defined	MAX QDS-1op
Sucralfate Tablets	Oral	1000	g	FOUR Times a Day	No duration defined	pods
Thiamine Hydrochloride Tablets	Oral	100	mg	THREE Times a Day	No duration defined	pods

lew Medication Started: yes

Medication Comment: Paracetmol PRN home only. GP changed citalopram to venlafaxine 75mg bd day prior to admission but patient continued to receive citalopram upon admission - no venlafaxine given. GP please review this upon discharge.

Discontinued Medication:

Drug Name	Dose	UOM	Reason

Yours sincerely,
Dr Michael Kinsella
Doctor

Prescription Review

Medications Reviewed by Pharmacist: Philip OBrien, Pharmacist
Dispensed Medications Checked by Pharmacy: Philip OBrien, Pharmacist
Nurse discharging patient: John McKay, Nurse

Weir James CHI: 1203893450

Immediate Discharge Letter

NHS Greater Glasgow and Clyde

Highly Sensitive: No Consent for Sharing Withheld: No

Dr. A Sunderland
Kingsinch Medical Practice
Renfrew Health Centre
10 Ferry Road
Renfrew
PA4 8RU

Royal Alexandra Hospital
Corsebar Road
Paisley
PA2 9PN
Main Switchboard: 0141-887-9111
Date of Completion: 03/01/2014

Dear Dr A Sunderland,

Name	CHI	DoB	Address
James Weir	1203893450	12/03/1989	17 Abercorn Street Paisley PA3 4AA

Admitted	Type	Discharged	Destination
02/01/2014 20:48	In Patient	03/01/2014	Private Residence - no additional detail added

Specialty	Consultant	Ward	Telephone
General Medicine	Dr Martin Perry	RAH AMU -Ward 2 General Medicine	0141-314-9756/9763

Reason for Admission and Presenting Complaints	Admission Category
	Admission for treatment - Where the patient is expected to be treated for a diagnosed condition not otherwise specified

Diagnosis	Site	Side
Acute Alcohol intoxication - Seizures (ICD10: F10.06)		

Date	Procedures/Interventions/Operations

Clinical Comments: Recent addmission due to seizure, had a negative CT at this point and is due to see neurology at SGH. Addmitted following a seizure whilst playing on an xbox, denies alcohol excess, only had a few beers at New Year.. Neurology normal. No further seizures, fit for home

Treatments: None recorded.

Follow-up arranged: Already has neuro appointment at SGH

Planned Outpatient Investigations: None

Final Discharge letter to follow: Yes

Medication Info:

Allergies:

Height: cm **Weight:** kg

Discharge Medication:

Medicine	Route	Dose	UOM	Frequency	Duration	Pharmacy Comment
Citalopram Tablets	Oral	20	mg	ONCE a Day	No duration defined	
Lactulose Solution	Oral	15	ml	TWICE a day	No duration defined	
Laxido Sachet	Oral	1	sachet(s)	THREE Times a Day	No duration defined	
Omeprazole Capsules	Oral	20	mg	ONCE a Day	No duration defined	
Sucralfate Tablets	Oral	1	g	FOUR Times a Day	No duration defined	
Thiamine Hydrochloride Tablets	Oral	100	mg	THREE Times a Day	No duration defined	

Discontinued Medication:

Drug Name	Dose	UOM	Reason

Yours sincerely,
Dr Sophie Flood
Doctor

Prescription Review

Medications Reviewed by Pharmacist: ,
Dispensed Medications Checked by Pharmacy: ,
Nurse discharging patient: Elaine Lowrie, Nurse Band 5

Weir James CHI: 1203893450

Immediate Discharge Letter

NHS
Greater Glasgow and Clyde

Highly Sensitive: No Consent for Sharing Withheld: No

Royal Alexandra Hospital
Corsebar Road
Paisley
PA2 9PN
Main Switchboard: 0141-887-9111
Date of Completion: 18/12/2013

Dr. A Sunderland
Kingsinch Medical Practice
Renfrew Health Centre
10 Ferry Road
Renfrew
PA4 8RU

Dear Dr A Sunderland,

Name	CHI	DoB	Address
James Weir	1203893450	12/03/1989	17 Abercorn Street Paisley PA3 4AA

Admitted	Type	Discharged	Destination
12/12/2013 23:47	In Patient	18/12/2013	Private Residence - no additional detail added

Specialty	Consultant	Ward	Telephone
General Surgery	Mr Mark Vella	RAH 28 - Urology	0141 314 7028

Reason for Admission and Presenting Complaints	Admission Category
Epigastric, LIF and Left loin pain.	Acute Admission no additional detail added

Diagnosis	Site	Side
Abdominal pain - Unspecified (ICD10: R10.4)		

Date	Procedures/Interventions/Operations

Clinical Comments:

Dx: 1) Biliary gastritis. 2)Constipation.
This 24 year old man who is a known heavy alcohol drinker presented with left iliac fossa, epigastric and loin pain radiating to his groin, complaining of nausea but no vomiting.He also complained of some dysuria and voiding difficulties on admission. On examination he was tender epigastrically as well as in the left iliac fossa.
We were concerned about the possibility of renal stones, and prescribed tamsulosin as we awaited a CT KUB. Abdominal xray showed faecal loading, thus we have given lactulose and laxido. CT abdomen was suggestive of pyelonephritis, but blood tests were unremarkable and MSSU was negative so we have not given any antibiotics. An OGD was performed which showed evidence of biliary gastritis and so we have increased omeprazole and added sucralfate.
We plan to review in Mr Vella's clinic in 3 months.

Treatments:

As noted.

Follow-up arranged: Mr Vella clinic 3/12

Planned Outpatient Investigations: Nil

Final Discharge letter to follow: y

Medication Info:

Allergies:

Height: cm **Weight:** kg

Discharge Medication:

Medicine	Route	Dose	UOM	Frequency	Duration	Pharmacy Comment
Citalopram Tablets	Oral	20	mg	ONCE a Day	No duration defined	pod @ home
Co-codamol 30/500 Tablets	Oral	2	tablet(s)	As Required	No duration defined	Max 6 hourly as required for pain-1op
Lactulose Solution	Oral	15	ml	TWICE a day	No duration defined	1op
Laxido Sachet	Oral	1	sachet(s)	THREE Times a Day	No duration defined	1op
Omeprazole Capsules	Oral	40	mg	ONCE a Day	No duration defined	28x20mg
Sucralfate Tablets	Oral	1	g	FOUR Times a Day	No duration defined	47
Tramadol Capsule	Oral	100	mg	As Required	No duration defined	As required for pain max 6 hourly-30x50mg

Discontinued Medication:

Drug Name	Dose	UOM	Reason
Diclofenac Sodium Dispersible Tablets	50	mg	Adverse Drug Reaction

Yours sincerely,
Jr Andrew Smith3
Doctor

Prescription Review
Medications Reviewed by Pharmacist: ,
Dispensed Medications Checked by Pharmacy: Fiona MacGregor1, Pharmacist
Nurse discharging patient: John McKay, Nurse

Weir James CHI: 1203893450

Immediate Discharge Letter

Highly Sensitive: No Consent for Sharing Withheld: No

NHS Greater Glasgow and Clyde

Royal Alexandra Hospital
Corsebar Road
Paisley
PA2 9PN
Main Switchboard: 0141-887-9111
Date of Completion: 06/10/2013

Dr. A Sunderland
The Health Centre
103 Paisley Road
Renfrew
PA4 8LH

Dear Dr A Sunderland,

Name	CHI	DoB	Address
James Weir	1203893450	12/03/1989	FLAT 2/1 Renfrew PA4 8HD

Admitted	Type	Discharged	Destination
05/10/2013 04:56	In Patient	06/10/2013	

Specialty	Consultant	Ward	Telephone
General Medicine	Dr Yi Ling	RAH 11 General Medicine	0141 314 7011

Reason for Admission and Presenting Complaints	Admission Category
	Admission for treatment - Where the patient is expected to be treated for a diagnosed condition not otherwise specified

Diagnosis	Site	Side

Date	Procedures/Interventions/Operations

Clinical Comments: Dear Doctor,

Mr Weir is a 24 year old gentleman who was admitted to hospital following an apparent seizure after taking '3 blue tablets' which he believes to have been valium. Mr Weir reports feeling unwell immediately after taking these, and believes he had a seizure as he had to lay on the floor for approx. 30 minutes. He states he did not lose consciousness but felt very drowsy and his friend brought him to A&E.

Mr Weir has a history of alcohol excess and depression. He reports having other 'seizures' over the past couple of months where he is unable to account for periods of time. We have informed Mr Weir that he must avoid driving for 6 months from the date of his last seizure, and advised him to inform the DVLA.

Routine bloods were unremarkable. ECG showed normal sinus rhythm. CT head scan was normal with no evidence of intracranial pathology. Mr Weir will be referred to the seizure clinic to further investigate these episodes. All routine observations have been normal during his stay in hospital and he is medically fit for discharge. He is currently on no regular medications.
Kind regards,
Amy Gardiner
FY1 CCU RAH 56075#

Treatments: None recorded.

Follow-up arranged: Seizure clinic

Planned Outpatient Investigations: None

Final Discharge letter to follow: Yes

Medication Info:

Allergies:

Height: cm **Weight:** kg

Discharge Medication:

Medicine	Route	Dose	UOM	Frequency	Duration	Pharmacy Comment

Discontinued Medication:

Drug Name	Dose	UOM	Reason

Yours sincerely,
Dr Amy Gardiner
Doctor

Prescription Review
Medications Reviewed by Pharmacist: ,
Dispensed Medications Checked by Pharmacy: ,
Nurse discharging patient: Lesley Tazzar, Nurse

Immediate Discharge Letter

NHS
Greater Glasgow and Clyde

Dr. CJ Johnstone
The Barony Practice
Northcroft Medical Centre
Paisley
PA3 4AD

Royal Alexandra Hospital
Corsebar Road
Paisley
PA2 9PN

Main Switchboard: 0141-887-9111

Date of Completion: 10/11/2012

Highly Sensitive: No
Consent for Sharing Withheld: No

Dear Dr CJ Johnstone,

Patient

Name:	**Weir James**
CHI:	**1203893450**
DOB:	**12 Mar 1989**
Address:	**1/2 24 Maxwellton Street** **Paisley** **PA1 2UB**
Long Term Conditions:	

Admission

Admitted:	**09/11/2012 08:00**
Discharged:	
Admission Type:	**In Patient**
Discharge to:	
Consultant:	**Mr Patrick Finn**
Specialty:	**General Surgery**
Ward:	**RAH 26 - General Surgery**
Ward Tel:	**0141 314 7026**
Ward Fax:	

Reason for Admission: **Admission for treatment - Where the patient is expected to be treated for a diagnosed condition not otherwise specified**

Treatments: **None recorded.**

Clinical Comments:

Mr Weir presented to RAH for an elective left inguino scrotal hernia repair on 9/11/12. There were no complications and he is now fit for discharge.

Follow-up arranged?:

Requested Outpatient Investigations:

Final Discharge letter to follow:

Medication Info:

Allergies:

Height: **cm** Weight: **kg**

Discharge Medication:

Medicine	Formulation	Route	Dose	UOM	Frequency	Duration
Paracetamol Tablets	**Tablets**	**Oral**	**1000**	**MG**	**Every 4 - 6 Hours when required**	**No duration defined**
Pharmacy Comment: 2op 64x500mg M&A						
Ibuprofen Tablets	**Tablets**	**Oral**	**400**	**MG**	**Every 6 - 8 Hours when required**	**No duration defined**
Pharmacy Comment: 1op 24 M&A						

New Medication Started:

Medication Comment:

Medication compliance aid:

Discontinued Medication:

Yours sincerely,

Gillian Higgins

Doctor

cc. 1. Dr CJ Johnstone

Prescription Review

Medications Reviewed by Pharmacist: **Lauren Marshall, Pharmacist**

Dispensed Medications Checked by Pharmacy: **Lauren Marshall, Pharmacist**

Nurse discharging patient: **Kelly Connery, Nurse**

Immediate Discharge Letter

NHS
Greater Glasgow and Clyde

Dr. CJ Johnstone
Craiglockhart Medical Group
Craiglockhart Surgery
161 Colinton Road
Edinburgh
EH14 1BE

Royal Alexandra Hospital
Corsebar Road
Paisley
PA2 9PN

Main Switchboard: 0141-887-9111

Date of Completion: 03/10/2012

Highly Sensitive: No
Consent for Sharing Withheld: No

Dear Dr CJ Johnstone,

Patient

Name:	**Weir James**
CHI:	**1203893450**
DOB:	**12 Mar 1989**
Address:	**1/2 24 Maxwellton Street** **Paisley** **PA1 2UB**
Long Term Conditions:	

Admission

Admitted:	**03/10/2012 04:36**
Discharged:	**03/10/2012**
Admission Type:	**In Patient**
Discharge to:	
Consultant:	**Dr Alistair Cormack**
Specialty:	**Cardiology**
Ward:	**RAHCCU - Coronary Care Unit**
Ward Tel:	**0141 314 7012**
Ward Fax:	

Reason for Admission: **Acute Admission no additional detail added**

Treatments: **None recorded.**

Clinical Comments:

Admitted with pericarditis.
Troponin negative. ECHO NAD.

Follow-up arranged?:

Requested Outpatient Investigations:

Final Discharge letter to follow:

Medication Info:

Allergies:
Height: **cm** Weight: **kg**

Discharge Medication:

Medicine	Formulation	Route	Dose	UOM	Frequency	Duration

New Medication Started:
Medication Comment: **Patient has own meds.**
Medication compliance aid:

Discontinued Medication:

Yours sincerely,

cc. 1. Dr CJ Johnstone

Prescription Review
Medications Reviewed by Pharmacist: ,
Dispensed Medications Checked by Pharmacy: ,
Nurse discharging patient: **Nyree Peebles, Nurse**

Letter to Patient: WIN782638

NHS
Greater Glasgow and Clyde

Royal Alexandra Hospital
Corsebar Road
Paisley
PA2 9PN
0141-887-9111
Gastroenterology
0141-314-6861
Mrs Lynne Mellstrom
03/06/2015
MH/CAD/RAH309548
26/05/2015
01/06/2015

James Weir
27D MACDOWALL STREET
Johnstone
Renfrewshire
PA5 8QJ

Main Switchboard:
Department:
Contact Tel:
Enquiries to:
Letter Date:
Reference:
Dictated Date:
Transcribed Date:

Dear Mr Weir,

This is a brief note to let you know about the endoscopy you recently had. This did show some inflammation in your stomach and from the sample that was taken this inflammation is due to the bug helicobacter pylori.

I would suggest that you see your GP to have this eradicated with standard triple therapy.

I do not feel that you need routine follow up. However, if there are any issues in the future then please do not hesitate to contact us again via your GP who will update us on your behalf.

Yours sincerely

Dr M HEYDTMANN MD FRCP PhD
CONSULTANT GASTROENTEROLOGIST & HEPATOLOGIST
m.heydtmann@nhs.net

Electronically Signed: Dr Mathis Heydtmann, Consultant

cc. Dr E C Renwick
Quarryside Practice
Linden Medical Centre
25 Floors Street
JOHNSTONE
PA5 8PZ

Letter to Patient:

NHS
Greater Glasgow and Clyde

Royal Alexandra Hospital
Corsebar Road
Paisley
PA2 9PN
Main Switchboard: 0141-887-9111
Department: Acute Medical Unit
Contact Tel: 0141 314 9777
Enquiries to: Theresa.Porter2@ggc.scot.nhs.uk

James Weir
27D MACDOWALL STREET
Johnstone
Renfrewshire
PA5 8QJ

Letter Date: 21/05/2015
Reference: IK/TP
Dictated Date: 18/05/2015
Transcribed Date: 19/05/2015

Dear Mr Weir,

I am sorry you could not attend for the endoscopy which was requested due to an episode of possible vomitting up blood. If you would like this test, please contact us and we will re-quest it again.

Yours sincerely

Dr Iain Keith
Consultant Physician in Acute Medicine

Electronically Signed: ,

cc. Dr. DA Foster
Dr D A Foster & Dr A E Crawford
The Health Centre
20 Duncan Street
Greenock
PA15 4LY

Letter to Patient:

NHS
Greater Glasgow and Clyde

Royal Alexandra Hospital
Corsebar Road
Paisley
PA2 9PN
Main Switchboard: 0141-887-9111
Department: Acute Medical Unit
Contact Tel: 0141 314 9777
Enquiries to: Theresa.Porter2@ggc.scot.nhs.uk
Letter Date: 24/10/2014
Reference: HS/TP
Dictated Date: 13/10/2014
Transcribed Date: 20/10/2014

James Weir
69C DUNDONALD ROAD
Paisley
Renfrewshire
PA3 4NB

Dear Mr Weir,

Following your recent admission in August we had arranged for you to undergo an endoscopy test to assess for causes of bleeding. Unfortunately you did not respond to the letters that were sent regarding this test. If you are still keen for this to proceed then I would be grateful if you could contact our secretary Theresa Porter on the above number and we will reappoint this.
Yours sincerely

Dr Hannah Simpson
ST7 in Acute Medicine

Electronically Signed: Doctor Hannah Simpson, Doctor

cc. Dr A Sunderland
Kingsinch Medical Practice
Renfrew Health Centre
10 Ferry Road
Renfrew
PA4 8RU

Case No 6675793 **Case Active** 12/05/2022 07:57 **Case Type** Ambulance

Patient James Weir **Sex** M **D.O.B** 12/03/1989 **Age** 33 years
Current Address
Flat D 27 Macdowall Street
Johnstone

PA5 8QJ
Current Phone: 07553 015425 **Home Phone:** **CHI:** 1203893450

Case Origin **Callers Name** James **Callers Tel:**

Own Doctor Renwick,Eilidh(CC)
Surgery Call Centre

NHS24 Received By Susan Drummond (Call Taker Si) ()
NHS24 Triage By Susan Drummond (Call Taker Si) ()
NHS24 Reported Condition
SAS Ref: 8661902 CHEST PAIN-15 HOURS

NHS24 Triage Start 08:01
NHS24 Triage End 08:19
NHS24 Outcome EMGI

NHS24 Recorded Allergies
PENICILLIN

NHS24 Recorded Medications

NHS24 Recorded Medical History

NHS24 Clinical Summary
Clinical summary created by: Susan Drummond (Call Taker Si) () [12/05/2022 08:19:38]
Reason for call: SAS Ref: 8661902 CHEST PAIN-15 HOURSConfirmed Symptom(s):
Chest pain described as constricting band
Endpoint Management Selected (CCT)
Chest pain

Symptom(s) not found:
No fever

Risk Factor(s):
No travel outside Europe in last 21 days or to an affected country

Call Detail(s):

Clinical supervisor (First Triage): DW CS G RAWLINGS
12:05:2022 07:58:55 DRUMMONDS.. NOT FEELING WELLHX ALCOHOLICBAD ABDO PAIN LOWER LEFT SIDE STOMACH -2 DAYSCHEST PAIN -15 HOURSVOMITING -CANT KEEP WATER DOWN,OR FOOD-NOT CONSTANT-2 DAY.. RETURN CALLER -CUT HAND OVER 1 WEEK AGO-CALL NHS 24DRINKING STUIPID AMOUNTS OF ALCOHOLBACK PAIN-CANT SIT DOWNPABERMAX JAG TODAYSHAKING -WHOLE BODY.. KW ADVICE DW CHEST/ABDO/VOMIT.. KW ADVICE TM M DUNCAN.. PAIN IN CHEST FRONTAL ,NOT CONSISTANT,COMES AND GOES-STABBING/TIGHTNESS/BAND SQUEEZING HEART.. CRUSHING DISCOMFORT,STANDING OR SITTING -COMES ON SUDDENLY.. ADVISED JUST VOMITED,REDDISH IN COLOUR.. DW CS G RAWLINGS-ALCOHOLIC,CHEST PAIN 15 HOURS,WHOLE BODY ACHING,SHAKING,HOT AND COLD SWEATS.QUERY WITHDRAWAL-999 AMBULANCE..
Outcome: 999 contacted - For information only

NHS24 Disposition
999 - Ambulance (ASAP)

NHS24 NUrse Comments

Reported Condition **Received By** **Received**

TAS Assessment **Assessed By** **TAS Assess Start**
TAS Assess End

Case No 6675793 **Case Active** 12/05/2022 07:57 **Case Type**Ambulance

Consultation **Consult By** **Consult Start**
Consult End

Examination Details **Clinical Codes**

Diagnosis

Treatment

Prescriptions

Follow-up(s)

Case No 6656553 **Case Active** 20/04/2022 10:33 **Case Type** Ambulance

Patient James Weir **Sex** M **D.O.B** 12/03/1989 **Age** 33 years
Current Address
Flat D 27 Macdowall Street
Johnstone

PA5 8QJ
Current Phone: 07553 015425 **Home Phone:** 07843 850737 **CHI:** 1203893450

Case Origin **Callers Name** James **Callers Tel:**

Own Doctor Renwick,Eilidh(CC)
Surgery Call Centre

NHS24 Received By Lukjeet Malhi (Call Taker SI) ()
NHS24 Triage By Lukjeet Malhi (Call Taker SI) ()
NHS24 Reported Condition
SAS Ref: 8584823 WOUND TO L WRIST 20-30 MINS

NHS24 Triage Start 10:34
NHS24 Triage End 10:55
NHS24 Outcome EMGI

NHS24 Recorded Allergies **NHS24 Recorded Medications** **NHS24 Recorded Medical History**

NHS24 Clinical Summary
Clinical summary created by: Lukjeet Malhi (Call Taker SI) () [20/04/2022 10:55:16]
Reason for call: SAS Ref: 8584823 WOUND TO L WRIST 20-30 MINSConfirmed Symptom(s):
New wound
Wound spurting/soaking through dressing (not discharge)
Endpoint Management Selected (CCT)

Symptom(s) not found:
No fever

Risk Factor(s):
No travel outside Europe in last 21 days or to an affected country

Call Detail(s):
Internal use only
Recommendation: KW Serious and Urgent
Internal use only
Outcome: 999 contacted - For information only

NHS24 Disposition
999 - Ambulance (ASAP)

NHS24 NUrse Comments

Reported Condition **Received By** **Received**

TAS Assessment **Assessed By** **TAS Assess Start**
TAS Assess End

Consultation **Consult By** **Consult Start**
Consult End

Examination Details **Clinical Codes**

Diagnosis

Case No 6656553 **Case Active** 20/04/2022 10:33 **Case Type** Ambulance

Treatment

Prescriptions

Follow-up(s)

Referral letter:

NHS
Greater Glasgow and Clyde

First Seizure Clinic
Neurology Department
Southern General Hospital
Govan Road
GLASGOW

Royal Alexandra Hospital
Corsebar Road
Paisley
PA2 9PN
Main Switchboard: 0141-887-9111

Department: Respiratory Medicine
Tel: 0141 314 7472
Enquiries to: hazel.giulianotti@ggc.scot.nhs.uk

Letter Date: 27/11/2013
Reference:
Dictated Date: 26/11/2013
Transcribed Date: 27/11/2013

Dear Colleague,

Name:	**Weir James**
CHI:	**1203893450**
DOB:	**12/03/1989**
Address:	**17 Abercorn Street**
	Flat 1-7
	Paisley
	Renfrewshire
	PA3 4AA

May I refer this patient to the first seizure clinic. I have enclosed a copy of the recent discharge summary for your information.

Yours sincerely

Dr Y Ling

Consultant Physician

Respiratory & General Medicine

Electronically Signed: Dr Yi Ling, Consultant

cc.

Final Discharge Letter

COPY
1st seizure clinic

NHS Greater Glasgow and Clyde

Dr. A Sunderland
The Health Centre
103 Paisley Road
Renfrew
PA4 8LH

Royal Alexandra Hospital
Corsebar Road
Paisley
PA2 9PN

Main Switchboard: 0141-887-9111

Date of Completion: 11/10/2013

Email Enquiries to: hazel.giulianotti@ggc.scot.nhs.uk
Contact Tel Details: 0141 314 7472

Dictated: 10/10/2013
Transcribed: 11/10/2013

Dear Dr. A Sunderland,

Patient

Name:	Weir James
CHI:	1203893450
DOB:	12/03/1989
Address:	FLAT 2/1
	Renfrew
	PA4 8HD

Admission

Admitted:	05/10/2013 04:56
Discharged:	06/10/2013 15:40
Admission Type:	In Patient
Discharge to:	Private Residence - living alone
Consultant:	Dr Yi Ling
Specialty:	General Medicine

Reason for Admission: Admission for treatment - Where the patient is expected to be treated for a diagnosed condition not otherwise specified

Clinical Comments:
Reason for admission: possible alcohol related seizure

Other diagnosis: excess alcohol intake, previous overdose

This 24 year old lives in a homeless shelter. He felt anxious on the day of admission. His friend offered him 3 blue tablets. Soon after ingestion of these unknown tablets he felt odd, was

hallucinating and had pins and needles all over his body. He then had a seizure that was witnessed by his friend. He also drank a litre of cider in the same evening an hour before he took those tablets. His blood results were all unremarkable.

By the time he was seen by the medical team he was back to his normal self. He had no further seizure activity in hospital. He was started on IV Pabrinex. He is already known to the alcohol liaison team. CT head was normal. He was advised he should not drive for at least 6 onths after his first onset seizure and he is aware he needs to inform the DVLA.

Follow up – referral to first seizure clinic.

Medication – as per immediate discharge summary dated 06/10/13.

Yours sincerely

Dr Yi Ling

Consultant Respiratory Physician

Electronically Signed: Dr Yi Ling, Consultant

cc. Dr Gautam Ray, Consultant Physician, RAH

Referral letter:

NHS
Greater Glasgow and Clyde

First Seizure Clinic
Neurology Department
Southern General Hospital
Govan Road
GLASGOW

Royal Alexandra Hospital
Corsebar Road
Paisley
PA2 9PN
Main Switchboard: 0141-887-9111

Department: Respiratory Medicine
Tel: 0141 314 7472
Enquiries to: hazel.giulianotti@ggc.scot.nhs.uk

Letter Date: 27/11/2013
Reference:
Dictated Date: 26/11/2013
Transcribed Date: 27/11/2013

Dear Colleague,

Name:	**Weir James**
CHI:	**1203893450**
DOB:	**12/03/1989**
Address:	**17 Abercorn Street** **Flat 1-7** **Paisley** **Renfrewshire** **PA3 4AA**

May I refer this patient to the first seizure clinic. I have enclosed a copy of the recent discharge summary for your information.

Yours sincerely

Dr Y Ling

Consultant Physician

Respiratory & General Medicine

Electronically Signed: Dr Yi Ling, Consultant

cc.

Hospital use only	Clinic	Day Date	Time	Hospital No.

	REFERRAL LETTER MEDICAL IN CONFIDENCE	**Attachments**

Additional Support Needs:
No known ASN requirements.

REFERRAL TO

General Surgery GGC General Referral	——	**Consultant / receiving practitioner** and/or **specialty clinic**
Royal Alexandra Hospital Corsebar Road Paisley PA2 9PN	——	**Hospital** and **hospital address** Hospital location code. C418H Email address -

Urgency of referral ROUTINE
Date of referral 16-Aug-2012 **Date sent** 16-Aug-2012

PATIENT DETAILS

Surname	WEIR
Forename(s)	JAMES
Title	MR
Sex	Male
Date of birth	12-Mar-1989
CHI no.	1203893450
Area of Residence	-

Patient's address

FL 1-2
24 MAXWELLTON STREET
PAISLEY
PA1 2UB

Contact number(s)

Voice: 07837232306

101004055911Q

Unique Care Pathway Number: 101004055911Q

REGISTERED GP DETAILS

Name	Dr C Johnstone		
GMC code	2596972	GP code	38571
Practice name	The Barony Practice		
Practice code	87606		

Practice address

NORTHCROFT MEDICAL CENTRE
NORTH CROFT STREET
PAISLEY
RENFREWSHIRE
PA3 4AD

Contact number(s)

Voice: 01418893732

REFERRING GP DETAILS

Name	Dr. John Hislop		
GMC code	2343590	GP code	38440
Practice name	The Barony Practice (87606)		
Practice code	87606		

Practice address

Northcroft Medical Centre
Paisley
PA3 4AD

Contact number(s)

Voice: 0141 889 3732

CLINICAL INFORMATION

History of presenting complaint
Presenting complaint

Description: inguinal hernia

Comment: Dear Dr,

This 23 year old man has a sizable inguinal hernia which is easily reducible. It is affecting his work as well as sport and he looks a good candidate for repair. I would welcome your opinion.

Yours sincerely
Dr John Hislop

Reason for referral

Care type requested: Out Patient

Expected outcome: Treat

Past medical history
Pre-existing conditions (High & medium priority - all)

Description	Comment	Date of onset	Date recorded
Bereavement reaction	[YEAR OF EVENT 2012]	01-Jan-2012	01-Jan-2012
Suicide selfinflicted poisoning by other drugs/medicines	[YEAR OF EVENT 2011] NOTES: OD paracetamol.	01-Jan-2011	01-Jan-2011
Suicide selfinflicted poisoning by other drugs/medicines	[YEAR OF EVENT 2011] NOTES: further OD paracetamol.	01-Jan-2011	01-Jan-2011
Other road vehicle accidents	[YEAR OF EVENT 2009] NOTES: HI # R tib/fib -> ORIF.	01-Jan-2009	01-Jan-2009
Suicide selfinflicted poisoning by other drugs/medicines	[YEAR OF EVENT 2007] NOTES: ? accidental overdose secondary to alcohol.	01-Jan-2007	01-Jan-2007
Alcohol problem drinking	[YEAR OF EVENT 2006]	01-Jan-2006	01-Jan-2006
Subject to supervision order under Children Act 1989	[YEAR OF EVENT 2004]	01-Jan-2004	01-Jan-2004
Suicide selfinflicted poisoning by other drugs/medicines	[YEAR OF EVENT 1998] NOTES: loperamide.	01-Jan-1998	01-Jan-1998
Child attention deficit disorder	[YEAR OF EVENT 1997]	01-Jan-1997	01-Jan-1997

Current medication (Active Repeat medication issued within the last 12 months)

No current medications recorded

Recent medication (Any medication issued within last 90 days not shown above)

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
FLUOXETINE caps 20mg	30	capsule	TAKE ONE DAILY	-	23-May-2012	23-May-2012
LANSOPRAZOLE caps(ec grans) 30mg	56	capsule	TAKE ONE ONCE DAILY	-	08-May-2012	08-May-2012

Blood Pressure

No Blood Pressures Recorded

Body Measurements

No Body Measurements Recorded

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Cigarette smoker:	Smoking status on date of event: Smoker, Number of cigarettes smoked per day: 20.	02-Jul-2012
Alcohol consumption:	alcohol XS . Drinks Fri and Sat	02-Jul-2012

Clinical warnings

Allergies

Description	Comment	Date recorded
H/O: drug allergy	Drug code for allergy: Benzylpenicillin 600mg powder for solution for injection vials, Reaction type: Allergy, Certainty of allergy: Possible, Severity of allergy: Moderate.	02-Jul-2012

Additional Support Needs

No known ASN requirements

Additional relevant information

Administrative information

OK to send correspondence to home address?:Yes

Patient will accept any site:Yes

Patient will accept cancellation or short notice appointment (within 1-6 days):Yes

Patient has disability or requires wheelchair access:No

Referred By:Referring GP

Electronic Attachment Present:No

Signature of referring doctor (or other professional) **Date**

Hospital use only	Clinic	Day Date	Time	Hospital No.

	REFERRAL LETTER MEDICAL IN CONFIDENCE	**Attachments**

Additional Support Needs:
No known ASN requirements

REFERRAL TO

Urology GGC General Referral	——	**Consultant / receiving practitioner** and/or **specialty clinic**
Royal Alexandra Hospital Corsebar Road Paisley PA2 9PN	——	**Hospital** and **hospital address** Hospital location code. C418H Email address -

Urgency of referral ROUTINE
Date of referral 09-Feb-2011 **Date sent** 10-Feb-2011

PATIENT DETAILS

Surname	WEIR
Forename(s)	JAMES THOMAS
Title	Mr
Sex	Male
Date of birth	12-Mar-1989
CHI no.	1203893450
Area of Residence	-

Patient's address

34 CANDREN ROAD
FERGUSLIE
PAISLEY
RENFREWSHIRE
PA3 1DW

Contact number(s)

Voice: 0141 848 9148

101001576442R Unique Care Pathway Number: 101001576442R

REGISTERED GP DETAILS

Name	Dr A Mahmood		
GMC code	3000515	GP code	C34444
Practice name	The Doctors Surgery		
Practice code	87485		

Practice address

The Tannahill Centre
76 Blackstoun Road
Paisley
PA3 1NT

Contact number(s)

Voice: 0141 889 7631
Facsimile: 0141 314 0528

REFERRING GP DETAILS

Name	Dr. Abdul Latif		
GMC code	1428218	GP code	38695
Practice name	THE TANNAHILL CENTRE (87485)		
Practice code	87485		

Practice address

76 Blackstoun Road
Paisley

Contact number(s)

Voice: 0141 889 7631

CLINICAL INFORMATION

History of presenting complaint
Presenting complaint

Description: cystic lesion L scrotum

Comment: Please see this gentleman who has a cystic lesion L scrotum ? fluid above L testicle. No pain. History a few years. Non tender. No trouble passing urine.
Regards

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history
Pre-existing conditions (High & medium priority - all)

Description	Comment	Modifier	Date of onset	Date recorded
Neurotic depression reactive type	-	-	17-Jan-2011	01-Nov-2010
Minor head injury	-	-	-	07-Oct-2009
[X]RTA - Road traffic and other transport accidents	-	Hosp. Admitted	-	07-Oct-2009
Closed fracture proximal tibia, lateral condyle (plateau)	-	Right	-	07-Oct-2009
Closed fracture shaft of fibula	-	Right	-	07-Oct-2009
[X]Attention deficit hyperactivity disorder	-	-	-	15-Sep-2008
Intoxication - alcohol	-	-	-	13-Oct-2007
Overdose of drug	paracetamol	-	-	13-Aug-2007
Overdose of drug	paracetamol	-	-	13-Jul-2007
Cause of overdose - accidental	paracetamol for toothache	-	-	21-Sep-2006
Alcohol problem drinking	-	-	-	21-Aug-2006
Intoxication - alcohol	-	-	-	29-Mar-2006
Collapse - symptom	alcohol related	-	-	29-Mar-2006
Behavioural problem	on Ritalin.	-	-	21-Aug-1997

Family conditions (All priorities)

Description	Date of Onset
No FH: Ischaemic heart disease	05-Jan-2007
No family history diabetes	05-Jan-2007

Current medication (Active Repeat medication issued within the last 12 months)

No current medications recorded

Recent medication (Any medication issued within last 90 days not shown above)

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Ibuprofen	24	TABS 400MG	1 Tab	3 times daily	09-Feb-2011	09-Feb-2011
Citalopram	28	TABS 20MG	1 Tab	Daily disp weekly	09-Feb-2011	09-Feb-2011
Citalopram	28	TABS 20MG	1 Tab	Daily disp weekly	10-Jan-2011	10-Jan-2011
Citalopram	28	TABS 20MG	1 Tab	Daily disp weekly	09-Dec-2010	09-Dec-2010
Citalopram	28	TABS 20MG	1 Tab	Daily disp weekly	17-Nov-2010	17-Nov-2010
Citalopram	28	TABS 20MG	1 Tab	Daily disp weekly	04-Nov-2010	04-Nov-2010
Nicotinell Tts 30	7	21mg/24 Hours PATCH	use	as directed	04-Nov-2010	04-Nov-2010

Blood Pressure

No Blood Pressures Recorded

Body Measurements

No Body Measurements Recorded

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Never smoked tobacco:		04-Nov-2010
Never smoked tobacco:		12-Aug-2009
Never smoked tobacco:		30-Dec-2008
Never smoked tobacco:		05-Jan-2007
Never smoked tobacco:		15-Mar-2006
Stopped drinking alcohol:		04-Nov-2010
Teetotaller:		30-Dec-2008
Teetotaller:		05-Jan-2007
Teetotaller:		07-Sep-2005
Enjoys moderate exercise:		05-Jan-2007
Enjoys moderate exercise:		07-Sep-2005

Clinical warnings

Additional Support Needs

No known ASN requirements

Additional relevant information

Administrative information

Previous Surname:FORREST

OK to send correspondence to home address?:Yes

Patient will accept any site:Yes

Patient will accept cancellation or short notice appointment (within 1-6 days):Yes

Patient has disability or requires wheelchair access:No

Referred By:Referring GP

Electronic Attachment Present:No

Signature of referring doctor (or other professional) **Date**

Gastroscopy report

Performed	22-May-2015 12:47	Received	22-May-2015 16:58
Reported	22-May-2015 16:58	Order Number	UNI65429-1203893450
Status	Final	Source System	MasterLab

UGI G1 Final

GASTROSCOPY REPORT

Name:	**James WEIR, 12/03/1989 (M)**	Address:	**27d MacDowall Street Johnstone Renfrewshire PA5 8QJ**
CHI No:	**1203893450**		
Case Note No:	**RAH309548**		
GP:	**RENWICK, EILIDH Quarryside Practice Linden Medical Centre 25 Floors Street Johnstone PA5 8PZ**	Status:	**Inpatient/NHS**
		Hospital:	**Royal Alexandra Hosp**
		Ward:	**(none)**
		Referring Cons:	**Dr. Mathis Heydtmann (Medical)**

Procedure date: 22 May 2015

Indications
Abdominal pain and dyspepsia.
Clinically important comments:
Recent episode of haematemsis.
Vomits after eating and notices some haematemesis, last episode 1 week ago.
Complaining of lower abdominal pain, no alteration in bowel habit.
Currently taking Ibuprofen for lower back pain with gaviscon for dyspepsia.

Consultant/Endoscopist
List consultant: Clyde pooled list
Endoscopist No1: Alison Nardini
Nurses: SN Alison Findlay
Staff Nurse Chavone Hillman

Instrument
SCANTRACK

Premedication
Xylocaine (Spray) 100 mg

Report
Apparent mucosal junction at 38cm from the incisors.
STOMACH. Gastritis: moderate erythematous/exudative with no bleeding in an area extending from the lesser curve prepyloric region through the prepyloric region, antrum, lower body, greater curve lower body, greater curve middle body, fundus and upper body.

Diagnoses
OESOPHAGUS. Normal.
STOMACH. Gastritis.
DUODENUM. Normal.

Specimens Taken
Urease test for H.pylori from prepyloric region

Follow up
Referring consultant will write with the pathology results and any further follow up.

Advice/Comments
Moderate gastritis, clo test taken. If positive will require eradication therapy.
No evidence of oesophageal or gastric varices.
Advised to see GP for PPI due to moderate gastritis to see if this will alleviate his symptoms.

CLO test positive

***** END OF REPORT *****

Gastroscopy report

Performed	17-Dec-2013 17:01	Received	17-Dec-2013 17:03
Reported	17-Dec-2013 17:03	Order Number	UNI52034-1203893450
Status	Final	Source System	MasterLab

UGI G1 Final

GASTROSCOPY REPORT

Name:	**James WEIR, 12/03/1989 (M)**	Address:	**17 Abercorn Street Flat 1-7 Paisley Renfrewshire PA3 4AA**
CHI No:	**1203893450**		
Case Note No:	**RAH309548**		
GP:	**SUNDERLAND, ANNE Kingsinch Medical Practice Renfrew Health Centre 10 Ferry Road Renfrew PA4 8RU**	Status:	**Outpatient/NHS**
		Hospital:	**Royal Alexandra Hosp**
		Ward:	**Ward - Not specified**
		Referring Cons:	**Mr M Vella (Surgical)**

Procedure date: 17 December 2013

Indications
Abdominal pain.

Consultant/Endoscopist
List consultant: Mr A Buter
Endoscopist No1: DR Robert Drummond

Report
Apparent mucosal junction at 40cm from the incisors.
STOMACH. Gastritis: moderate erythematous/exudative with no bleeding in an area extending from the antrum through the greater curve antrum, greater curve lower body, greater curve middle body and lesser curve middle body.

Instrument
SCANTRACK

Premedication
Midazolam (IV) 4 mg

Diagnoses
OESOPHAGUS. Normal.
STOMACH. Gastritis.
DUODENUM. Normal.

Specimens Taken
Biopsy (x1 from an area extending from the antrum through the greater curve antrum, greater curve lower body, greater curve middle body and lesser curve middle body)

Follow up
Awaiting pathology results. Return to the Ward.

Advice/Comments

Some bile present in the stomach.
Associated distal gastritis. Normal D1/2
CLO test and gastric biopsies taken

Would suggest trial of sucralfate & PPI

***** END OF REPORT *****

Gastric Biopsy

Performed	17-Dec-2013 00:00	Received	17-Dec-2013 18:48
Reported	03-Jan-2014 14:29	Order Number	D,13.0092273.E
Status	Final	Source System	Telepath

Pathology Final

NHS GREATER GLASGOW AND CLYDE
PATHOLOGY DEPARTMENT ENQUIRIES TO: 0141-354-9487 (89487)

Date collected: 17.12.2013
Date received : 17.12.2013 Date reported: 03.01.2014

Reporting Pathologist : Alan Foulis
Consultant Pathologist: Alan Foulis

CLINICAL HISTORY

Epigastric pain.

DISTAL GASTRIC BIOPSIES

MICROSCOPY:
Microscopy of these two biopsies shows mild chronic inflammation of the antral type mucosa. There is little evidence of active inflammation and helicobacter are not seen. There is no evidence of dysplasia or malignancy.

Professor A Foulis, Consultant
Dictated: 3/1/14
Typed: 3/1/14 JM
Authorised: 03/01/14 by Alan Foulis

MEDICINE **PRESCRIPTION FORM**

Hospital Name: .....

MEDICINES RECONCILIATION

Medicines Reconciled on Admission YES ☐

Date _____ Name (Print) _____

Discharge Prescription Prepared & Reconciled YES ☐

Date _____ Name (Print) _____

Date and time this form prepared:	Sheet No	2nd Prescription in use
__/__/__ Time: _____	.....	YES ☐ NO ☐

DOCTOR'S DECLARATION (if required by Local Protocol)

I authorise nurse/midwife administration of the medicines included in the symptomatic relief policy & local protocol:

_____

with the following exceptions: _____

Print & Sign: _____ Date: _____

COMMUNITY PHARMACY INFORMATION

Name _____ Tel No. _____

Address _____

Compliance Aid Details _____

Patient consent to share discharge information Y/N

Print & Sign _____

PATIENT DETAILS

Hospital

DOB: 1203893450
WEIR M
James 12/03/1989
27D MACDOWALL STREET
Date of Johnstone, Renfrewshire
Consult PA5 8QJ

Height:

Weight:

Surface area:

Ward:

ONCE ONLY AND PREMEDICATION DRUGS

DATE	DRUG	DOSE	ROUTE	TIME (24hr)	PRESCRIBER (PRINT & SIGN)	GIVEN BY	TIME GIVEN (24hr)

TARGET OXYGEN SATURATIONS

Please CIRCLE a target saturation and prescribe oxygen on the Regular Prescription section.

94 – 98%	88 – 92% (e.g. in hypercapnic respiratory failure)	Other (please specify)
		90%

On Home Oxygen? Yes (No) ____ L/min

DATE: 10/06/20 PRESCRIBER (PRINT & SIGN): [signature]

	DATE →																							
	MONTH →																							
	RECORD OF THROMBOPROPHYLAXIS ASSESSMENT (IN EACH CASE RECORD WITH Y OR N - REASSESS NEED AT LEAST EVERY 48 HRS)																							
IS DRUG THROMBOPROPHYLAXIS INDICATED? Y / N																								
ARE ANTIEMBOLISM STOCKINGS INDICATED? Y / N																								
SIGNATURE OF ASSESSOR																								
ARE ANTIEMBOLIC STOCKINGS ON PATIENT? RECORD DAILY AT 1800 DRUG ROUND WITH Y OR N																								

Parenteral Drugs : Regular Prescription

																										Patient's Own Medicine
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐	A DRUG PABRINX. DOSE (1+1) K2 ROUTE IV DATE 10/6/20 STOPPED DATE: INITIALS: PRESCRIBER (PRINT & SIGN) ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY	Other time																								For Use Y/N
		0700-0900																								Qty:
		1200-1400																								Date:
		1600-1800																								Assessed by:
		2200-2400																								Ordered from Pharm.
		Other time																								
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐	B DRUG DOSE ROUTE DATE STOPPED DATE: INITIALS: PRESCRIBER (PRINT & SIGN) ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY	Other time																								For Use Y/N
		0700-0900																								Qty:
		1200-1400																								Date:
		1600-1800																								Assessed by:
		2200-2400																								Ordered from Pharm.
		Other time																								
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐	C DRUG DOSE ROUTE DATE STOPPED DATE: INITIALS: PRESCRIBER (PRINT & SIGN) ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY	Other time																								For Use Y/N
		0700-0900																								Qty:
		1200-1400																								Date:
		1600-1800																								Assessed by:
		2200-2400																								Ordered from Pharm.
		Other time																								

REVIEW THE NEED FOR IV ANTIBIOTIC DAILY. SWITCH TO ORAL THERAPY AS SOON AS POSSIBLE (SEE IVOST POLICY)

Parenteral Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

D DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

E DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

F DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

G DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

Oral and Other Drugs: Regular Prescription

DATE / MONTH

Patient's Own Medicine | For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time

H

BEFORE ADMISSION ☒ | NEW DOSE ☐ | NEW MEDICATION ☐

DRUG: MIRTAZEPINE

DOSE: 15mg | ROUTE: O | DATE: 10/6/20 | STOPPED DATE: | STOPPED INITIALS:

PRESCRIBER (PRINT & SIGN):

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

J

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☑

DRUG: DIAZEPAM.

DOSE: 2mg | ROUTE: PO | DATE: 10/6/20 | STOPPED DATE: | STOPPED INITIALS:

PRESCRIBER (PRINT & SIGN):

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

K

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

DRUG:

DOSE | ROUTE | DATE | STOPPED DATE: | STOPPED INITIALS:

PRESCRIBER (PRINT & SIGN):

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

L

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

DRUG:

DOSE | ROUTE | DATE | STOPPED DATE: | STOPPED INITIALS:

PRESCRIBER (PRINT & SIGN):

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

Note: To discontinue a prescription, initial and date appropriate boxes, draw a diagonal line through section & record reason

Oral and Other Drugs: Regular Prescription

| | | |

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time

Patient's Own Medicine | For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

S DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

T DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

V DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

W DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Note: To discontinue a prescription, initial and date appropriate boxes, draw a diagonal line through section & record reason

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

X DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

Y DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

AA DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

BB DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

CC DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

DD DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

EE DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

FF DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

Note: To discontinue a prescription, initial and date appropriate boxes, draw a diagonal line through section & record reason

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

GG DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

HH DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

JJ DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

KK DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

All Routes: As Required Prescriptions

Patient's Own Medicine

| | | |

BEFORE ADMISSION ☐	RR	DRUG	STOPPED DATE: INITIALS:	DATE																						Patient's Own Medicine For Use Y/N
NEW DOSE ☐		DOSE / ROUTE / INDICATION		TIME																						Qty:
		PRESCRIBER (PRINT & SIGN) / MAX.FREQ.	DATE:	DOSE																						Date:
NEW MEDICATION ☐		ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY		GIVEN BY																						Assessed by: / Ordered from Pharm.
BEFORE ADMISSION ☐	SS	DRUG	STOPPED DATE: INITIALS:	DATE																						For Use Y/N
NEW DOSE ☐		DOSE / ROUTE / INDICATION		TIME																						Qty:
		PRESCRIBER (PRINT & SIGN) / MAX.FREQ.	DATE:	DOSE																						Date:
NEW MEDICATION ☐		ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY		GIVEN BY																						Assessed by: / Ordered from Pharm.
BEFORE ADMISSION ☐	TT	DRUG	STOPPED DATE: INITIALS:	DATE																						For Use Y/N
NEW DOSE ☐		DOSE / ROUTE / INDICATION		TIME																						Qty:
		PRESCRIBER (PRINT & SIGN) / MAX.FREQ.	DATE:	DOSE																						Date:
NEW MEDICATION ☐		ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY		GIVEN BY																						Assessed by: / Ordered from Pharm.
BEFORE ADMISSION ☐	VV	DRUG	STOPPED DATE: INITIALS:	DATE																						For Use Y/N
NEW DOSE ☐		DOSE / ROUTE / INDICATION		TIME																						Qty:
		PRESCRIBER (PRINT & SIGN) / MAX.FREQ.	DATE:	DOSE																						Date:
NEW MEDICATION ☐		ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY		GIVEN BY																						Assessed by: / Ordered from Pharm.

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

Name _____

CHI No _____

Drug Allergies / Sensitivities **None Known** ☐ **Yes** ☒ **(provide details below)**

Penicillin

Nurse/Midwife Administration by Symptomatic Relief Policy or other Protocol - Authorised Nurses/Midwives Only (Maximum number of doses as per protocol)

Warning: Check the As Required and Regular Prescription sections to ensure that the drug has not already been prescribed by a doctor.

DATE	DRUG	DOSE	ROUTE	TIME (24hr)	NURSE (PRINT & SIGN)	GIVEN BY	TIME GIVEN (24hr)

Notes for Users

FOR PRESCRIBERS:

1. Prescribe drugs generically using the Approved Name (except in circumstances where bioavailability differences between brands of the same drug are so important as to warrant prescribing by brand name e.g. in the case of sustained release lithium or theophylline).
2. All prescription entries must be legible and made so as to be indelible (black ink is recommended).
3. Print & Sign your full name clearly against each prescription entry.
4. Time should be recorded in 24hr format e.g. 0600, 1800.
5. When drugs are discontinued, draw a diagonal line through the prescription box, initial and date the appropriate boxes and record reason.
6. If an existing prescription entry is to be modified, delete the existing prescription and re-write the new instructions as a new prescription entry.
7. The following metric unit abbreviations must be used –

Milligram = mg — Gram = g
Millilitre = ml — Millimoles = mmol
Microgram / Nanogram / Units – **Do not abbreviate, write in full**

Fractions of a milligram should be written in micrograms. The use of decimal points should be avoided, if possible. If decimal points must be used a zero must be written in front of the decimal point (e.g. 0.5ml **NOT** .5ml).

8. The route of administration can be abbreviated using the following -

O	= oral	ID	= intradermal
IM	= intramuscular	SL	= sublingual
SC	= subcutaneous	PR	= per rectum
NG	= nasogastric	PEG	= percutaneous endoscopic gastrostomy
PV	= per vagina	RIG	= radiologically inserted gastrostomy
NJ	= naso[e]junostomy	PEJ	= percutaneous endoscopic [e]junostomy
TOP	= topical	ETT	= endotracheal
NEB	= nebulised	INHAL	= inhaled
IV	= intravenous		

Please note - Intrathecal **must be written in full.**

FOR NURSES

1. The 'Once only', 'Regular' and 'As required' sections should be checked at each administration round to ensure that inadvertent omission or double dosing are avoided.
2. Insert initials in the relevant date column and time row each time a drug is administered.
3. Check that all drugs prescribed at a certain time have been administered.
4. If a drug is not administered enter the reason code in the appropriate date column and time row and also document the full reason in the patient's notes.

Codes for Non-Administration of Drugs

(3) Patient refused
(4) Drug not available
(5) Nil by mouth/fasting
(6) Patient unavailable
(7) Patient asleep
(8) Time varied on doctor's instructions
(9) Dose withheld on doctor's instructions
(10) Nausea/vomiting
(11) Unable to swallow
(12) No intravenous access
(13) Patient Self-Administration of Medicine
(14) Other - Record in nursing notes
(15) Prescription clarification required

Cat. No. 40995 Ver 4, 09/2010 GGC0029

Patient name: 1203893450
WEIR M
James
Date of birth: 12/03/1989
27D MACDOWALL STREET
Johnstone, Renfrewshire
CHI No: PA5 8QJ

ADULT FLUID AND ADDITIVE PRESCRIPTION AND ADMINISTRATION CHART

NHS Greater Glasgow and Clyde

Patient's weight and height

Weight (kg) ..... Height (cm) .....

Prescription details									Administration details				
Date	Time	Name of fluid / Name of additive	Volume (ml) / Dose	Route	Duration(hr) Or Flow rate (ml/hr)	Additional instructions	Prescriber's signature, PRINTED name and designation	*Discontinued by (initial, date and time)	Date	Time	Given by	Checked by	Comments
10/6/2		HARTMANNS	500	IV	4°								
-1		HARTMANNS	500	IV	4°								
-1		5% Dextrose	500	IV	4°								

*Prescriber should sign this box if the fluid/additive is no longer required.

Nursing staff guidance on using a drops/min flow rate (if administered by gravity flow)

Calculation:

Rate of flow (drops/min) = Volume of fluid (ml) x 20 / Duration of admin (min)

NB: 1ml = 20 drops (for a standard giving set)

Example:

500ml over 1 hour	167 drops/min
500ml over 4 hours	42 drops/min
500ml over 6 hours	28 drops/min
500ml over 8 hours	21 drops/min

Patient name:.....

Date of birth:.....

CHI No:.....

Affix patient label

ADULT FLUID AND ADDITIVE PRESCRIPTION AND ADMINISTRATION CHART

NHS Greater Glasgow and Clyde

Prescription details - continued									Administration details - continued				
Date	Time	Name of fluid Name of additive	Volume (ml) Dose	Route	Duration(hr) Or Flow rate (ml/hr)	Additional instructions	Prescriber's signature, PRINTED name and designation	*Discontinued by (initial, date and time)	Date	Time	Given by	Checked by	Comments

*Prescriber should sign this box if the fluid/additive is no longer required.

Weir, James ID:1203893450 12-MAY-2022 10:01:14 GREATER GLASGOW SITE-RAHAE ROUTINE RECORD

12-MAR-1989 (33 yr)
Male Caucasian

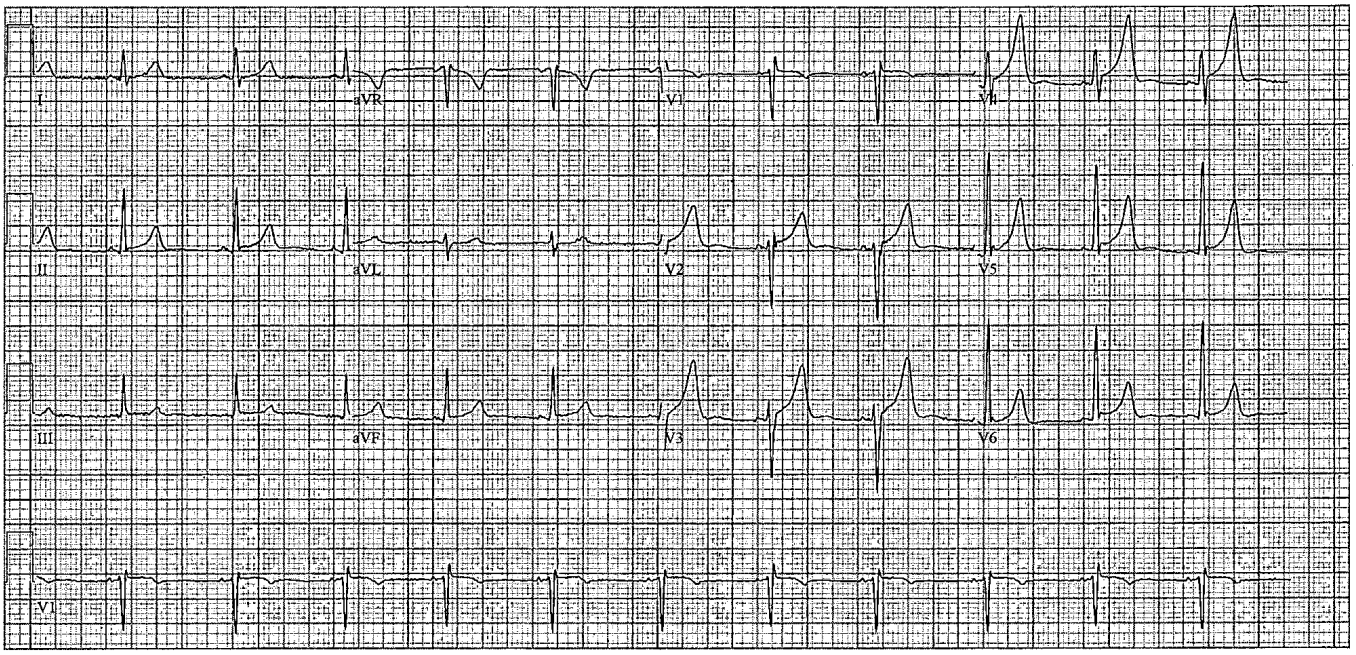
Room:CAS
Loc:800 Option:34

Vent. rate	70	BPM
PR interval	90	ms
QRS duration	82	ms
QT/QTc	374/403	ms
P-R-T axes	39 71	48

Sinus rhythm with short PR
RSR' or QR pattern in V1 suggests right ventricular conduction delay
Early repolarization

Technician: 834
Test ind:

Unconfirmed



25mm/s 10mm/mV 40Hz 9.0.10 12SL 239 CID: 30 SID: 2009502 EID: EDT: ORDER:

WEIR, James ID:1203893450 24-JUL-2017 17:41:14 GREATER GLASGOW SITE- ROUTINE RECORD

12-MAR-1989 (28 yr)
Male Caucasian

Room:

Vent. rate	105	BPM
PR interval	116	ms
QRS duration	84	ms
QT/QTc	322/425	ms
P-R-T axes	67 76	45

Sinus tachycardia

Technician: 500
Test ind:

Referred by:

UNCONFIRMED ECG REPORT Sys Admin 3



25mm/s 10mm/mV 150Hz 7.1.1 12SL 241 CID: 16

SID: 2009502 EID:21003 EDT: 14:33 28-JUL-2017 ORDER:

WEIR, James ID:1203893450 24-JUL-2017 17:25:27 GREATER GLASGOW SITE- ROUTINE RECORD

12-MAR-1989 (28 yr)
Male Caucasian

Room:

Vent. rate	104	BPM
PR interval	90	ms
QRS duration	78	ms
QT/QTc	314/412	ms
P-R-T axes	32 80	57

Sinus tachycardia with short PR

Technician: 500
Test ind:

Referred by:

UNCONFIRMED ECG REPORT Sys Admin 3



25mm/s 10mm/mV 150Hz 7.1.1 12SL 241 CID: 16

SID: 2009502 EID:21003 EDT: 14:33 28-JUL-2017 ORDER:

WEIR, James ID:1203893450 02-JUN-2016 12:30:25 GREATER GLASGOW SITE-RAHAE ROUTINE RECORD

12-MAR-1989 (27 yr)
Male Caucasian

Room:
Loc:800

Vent. rate	59	BPM
PR interval	114	ms
QRS duration	90	ms
QT/QTc	430/425	ms
P-R-T axes	43 73	53

Sinus bradycardia
RSR' or QR pattern in V1 suggests right ventricular conduction delay
ST elevation, probably due to early repolarization

Technician:
Test ind:

Referred by: UNCONFIRMED ECG REPORT Laura Campbell



25mm/s 10mm/mV 150Hz 7.1.1 12SL 239 CID: 1

EID:2894 EDT: 09:59 08-JUN-2016 ORDER:

WEIR, James ID:1203893450 10-AUG-2015 20:36:32 GREATER GLASGOW SITE-RAHAE ROUTINE RECORD

12-MAR-1989 (26 yr)
Male Caucasian

Room:
Loc:800

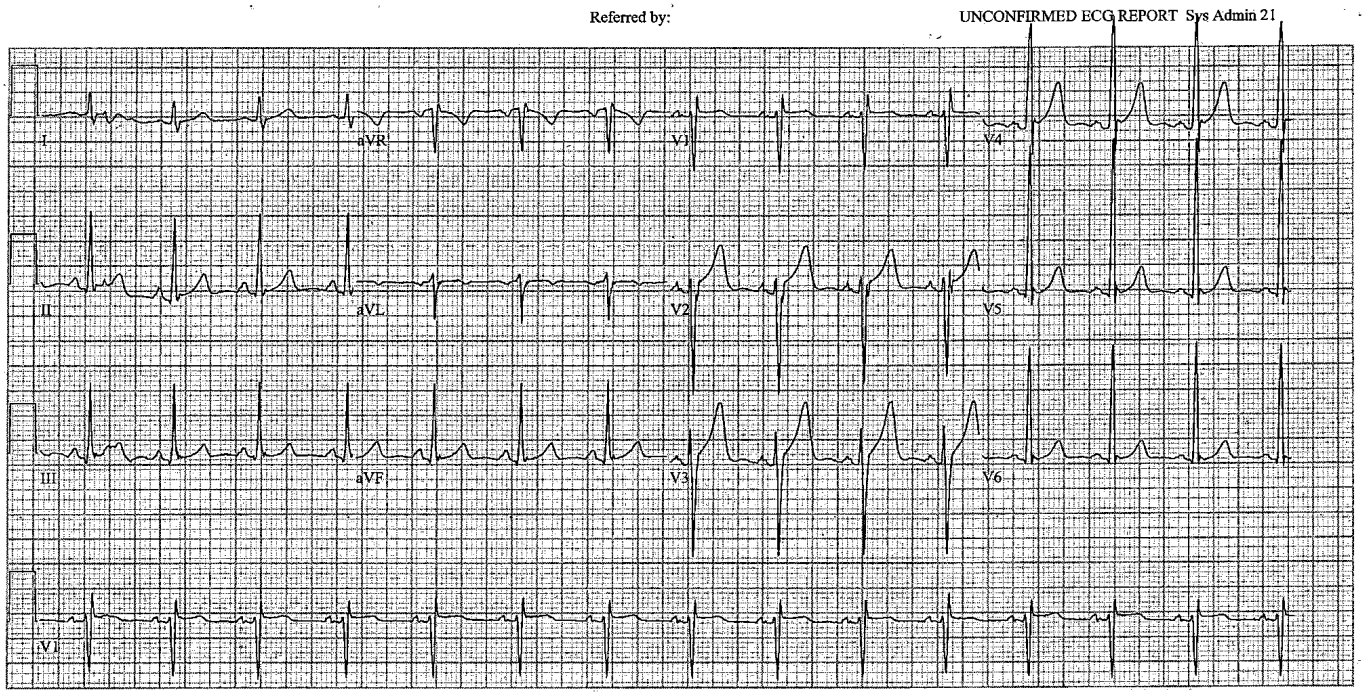
Vent. rate	88	BPM
PR interval	128	ms
QRS duration	92	ms
QT/QTc	356/430	ms
P-R-T axes	78 83	64

Normal sinus rhythm
Incomplete right bundle branch block
Minimal voltage criteria for LVH, may be normal variant

Technician:
Test ind:

Referred by:

UNCONFIRMED ECG REPORT Sys Admin 21



25mm/s 10mm/mV 150Hz 7.1.1 12SL 239 CID: 1

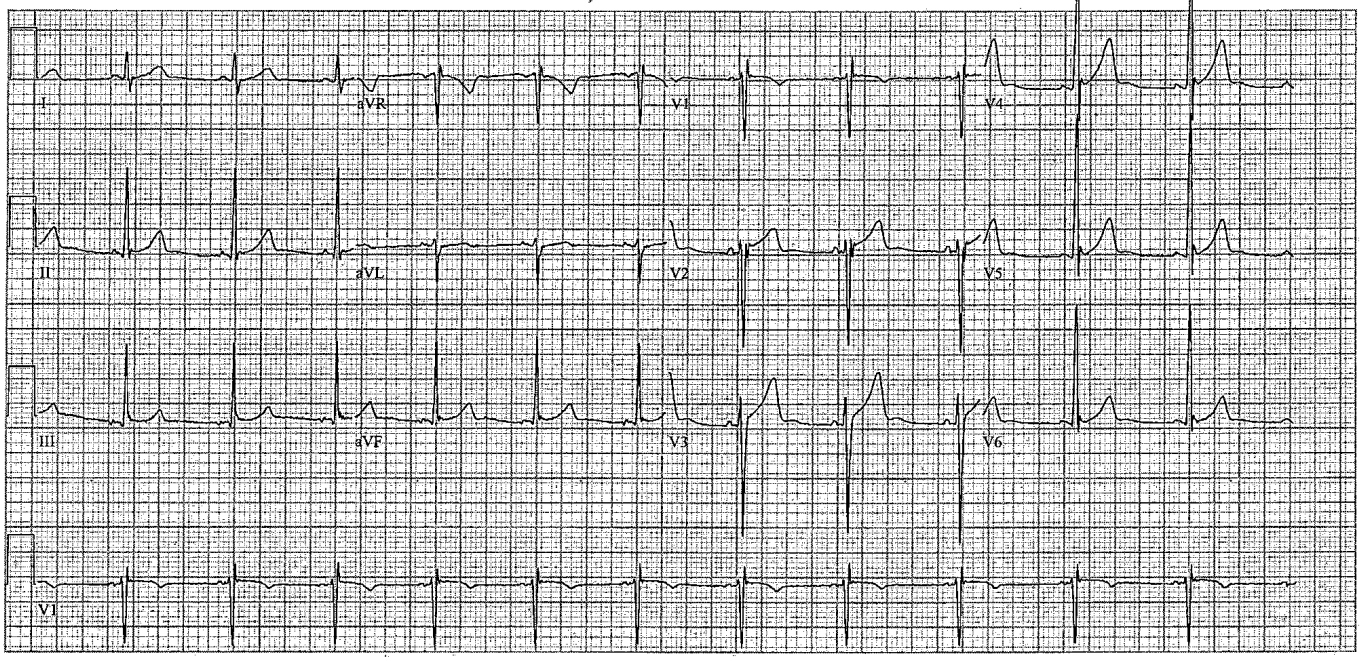
SID: 2009502 EID:21021 EDT: 14:51 07-SEP-2015 ORDER:

WEIR, James ID:1203893450 01-MAR-2015 14:22:31 GREATER GLASGOW SITE-RAHAE ROUTINE RECORD

12-MAR-1989 (25 yr)	Vent. rate	71	BPM	Sinus rhythm with short PR
Male Caucasian	PR interval	96	ms	RSR' or QR pattern in V1 suggests right ventricular conduction delay
	QRS duration	82	ms	
Room:CAS	QT/QTc	372/404	ms	
Loc:800 Option:34	P-R-T axes	20 82	56	

Technician: 834
Test ind:

Referred by: UNCONFIRMED ECG REPORT Sys Admin 21



25mm/s 10mm/mV 150Hz 7.1.1 12SL 239 CID: 1

SID: 2009502 EID:21021 EDT: 11:25 09-MAR-2015 ORDER:

WEIR, James ID:1203893450 15-AUG-2014 18:25:46 GREATER GLASGOW SITE-RAHAE ROUTINE RECORD

12-MAR-1989 (25 yr)
Male Caucasian

Room:
Loc:800

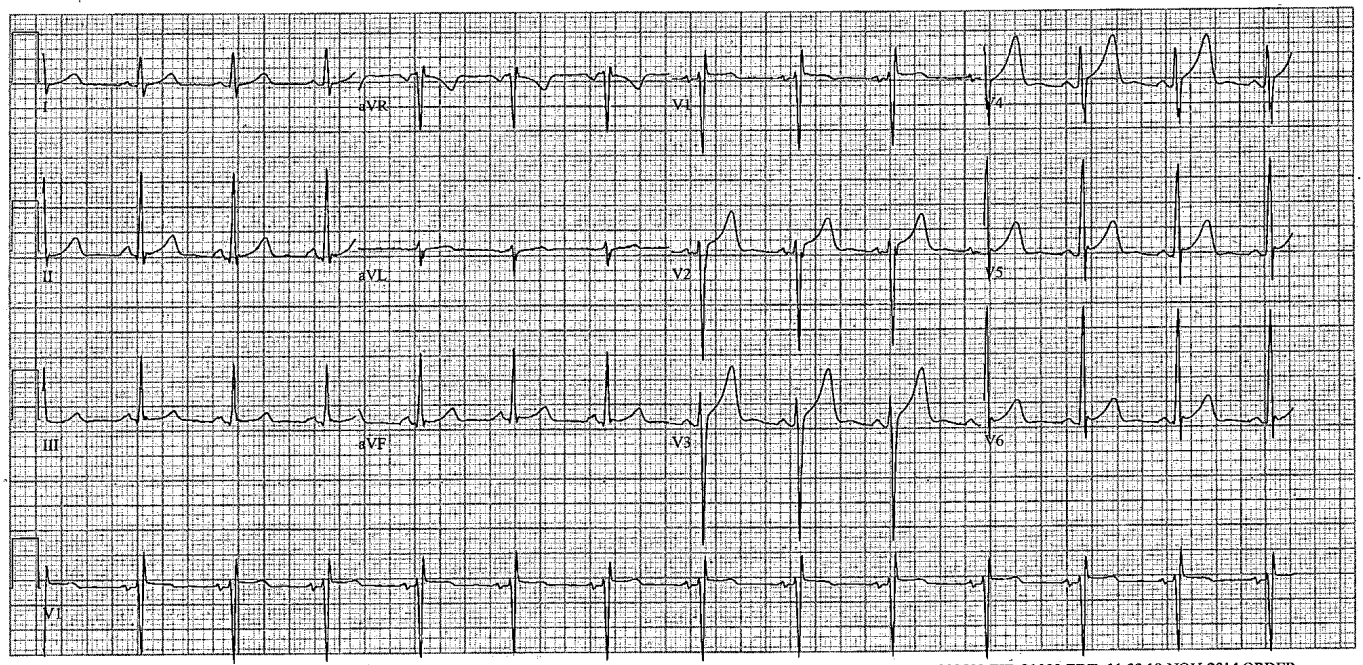
Vent. rate	80	BPM
PR interval	122	ms
QRS duration	88	ms
QT/QTc	376/433	ms
P-R-T axes	67 73	51

Normal sinus rhythm
RSR' or QR pattern in V1 suggests right ventricular conduction delay
ST elevation, probably due to early repolarization
Borderline ECG

Technician:
Test ind:

Referred by:

UNCONFIRMED ECG REPORT Sys Admin 3



25mm/s 10mm/mV 150Hz 7.1.1 12SL 237 CID: 10

SID: 2009502 EID:21003 EDT: 11:33 18-NOV-2014 ORDER:

WEIR, James ID:1203893450 13-AUG-2014 21:51:04 GREATER GLASGOW SITE-RAHAE ROUTINE RECORD

12-MAR-1989 (25 yr)
Male Caucasian

Room:
Loc:800

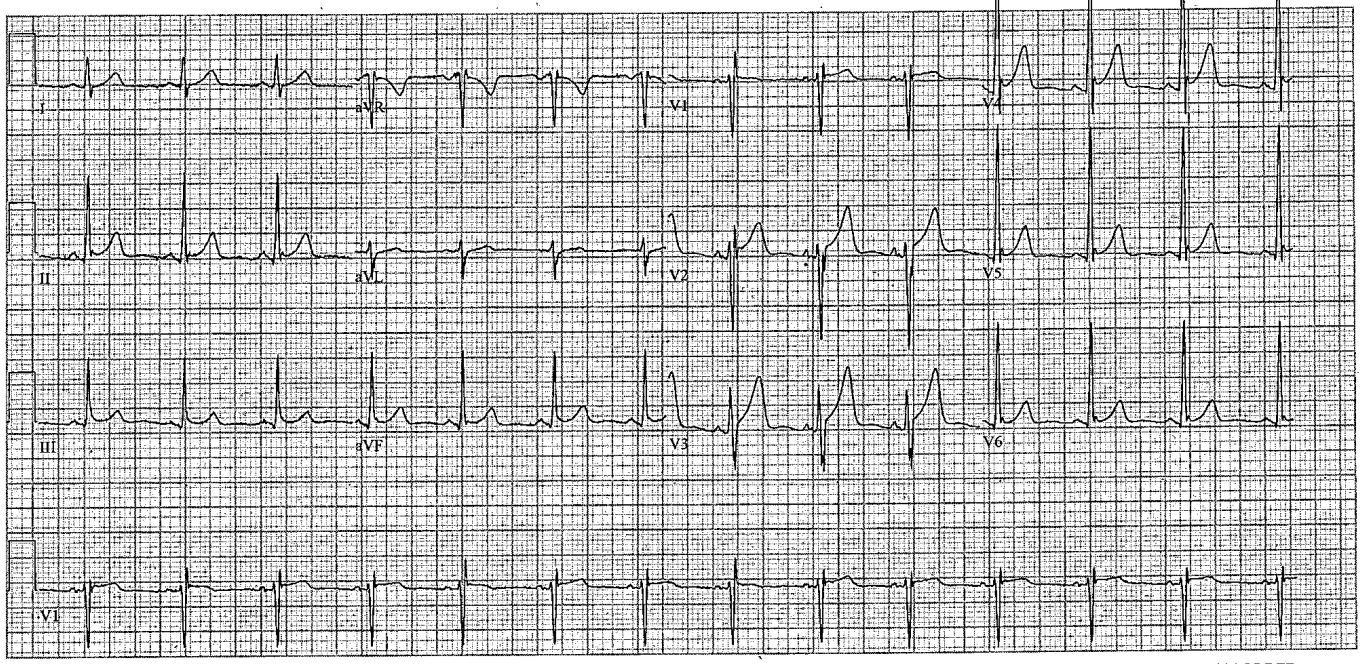
Vent. rate	82	BPM
PR interval	114	ms
QRS duration	88	ms
QT/QTc	348/406	ms
P-R-T axes	53 77	55

Normal sinus rhythm
RSR' or QR pattern in V1 suggests right ventricular conduction delay
Early repolarization
Borderline ECG

Technician:
Test ind:

Referred by:

UNCONFIRMED ECG REPORT Sys Admin 1



25mm/s 10mm/mV 150Hz 7.1.1 12SL 237 CID: 10

SID: 2009502 EID:21001 EDT: 14:18 25-SEP-2014 ORDER:

WEIR, James ID:1203893450 15-APR-2014 19:48:42 GREATER GLASGOW SITE- ROUTINE RECORD

12-MAR-1989 (25 yr)
Male Caucasian

Room:

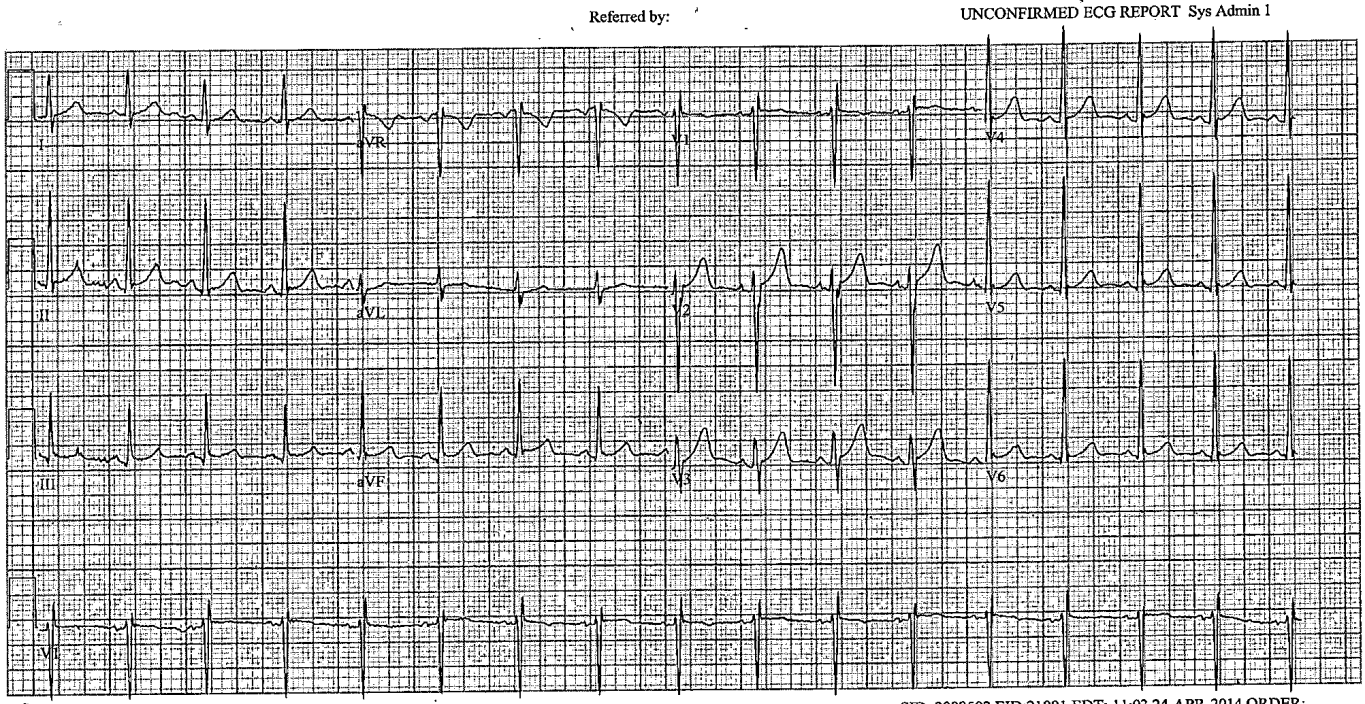
Vent. rate	98	BPM
PR interval	116	ms
QRS duration	82	ms
QT/QTc	336/428	ms
P-R-T axes	64 69	52

Normal sinus rhythm
RSR' or QR pattern in V1 suggests right ventricular conduction delay

Technician:
Test ind:

Referred by:

UNCONFIRMED ECG REPORT Sys Admin 1



25mm/s 10mm/mV 150Hz 7.1.1 12SL 239 CID: 1

SID: 2009502 EID:21001 EDT: 11:03 24-APR-2014 ORDER:

WEIR, James ID:1203893450 26-MAR-2014 19:23:25 GREATER GLASGOW SITE-RAHMAU ROUTINE RECORD

12-MAR-1989 (25 yr)
Male Caucasian

Room:
Loc:813

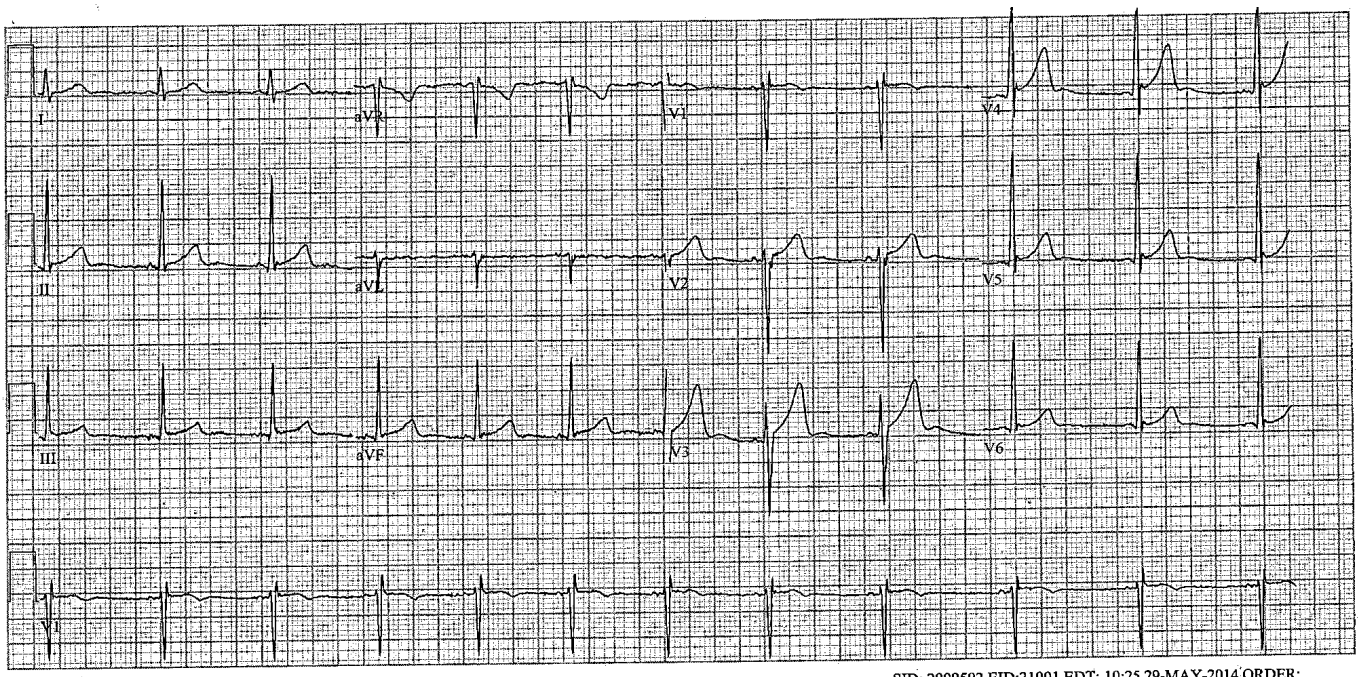
Vent. rate	68	BPM
PR interval	96	ms
QRS duration	80	ms
QT/QTc	384/408	ms
P-R-T axes	47 80	65

Sinus rhythm with sinus arrhythmia with short PR
RSR' or QR pattern in V1 suggests right ventricular conduction delay
Early repolarization

Technician: 500
Test ind:

Referred by:

UNCONFIRMED ECG REPORT Sys Admin 1



25mm/s 10mm/mV 150Hz 7.1.1 12SL 239 CID: 11

SID: 2009502 EID:21001 EDT: 10:25 29-MAY-2014 ORDER:

WEIR, JAMES ID: 1203893450 12-May-2022 10:01:14 A&E 023022

12-Mar-1989
Male Caucasian
Room: CAS
Loc: 800 Opt: 34

Vent. rate bpm
PR interval 90 ms
QRS duration 82 ms
QT/QTc 374/403 ms
P-R-T axes 39 71 48

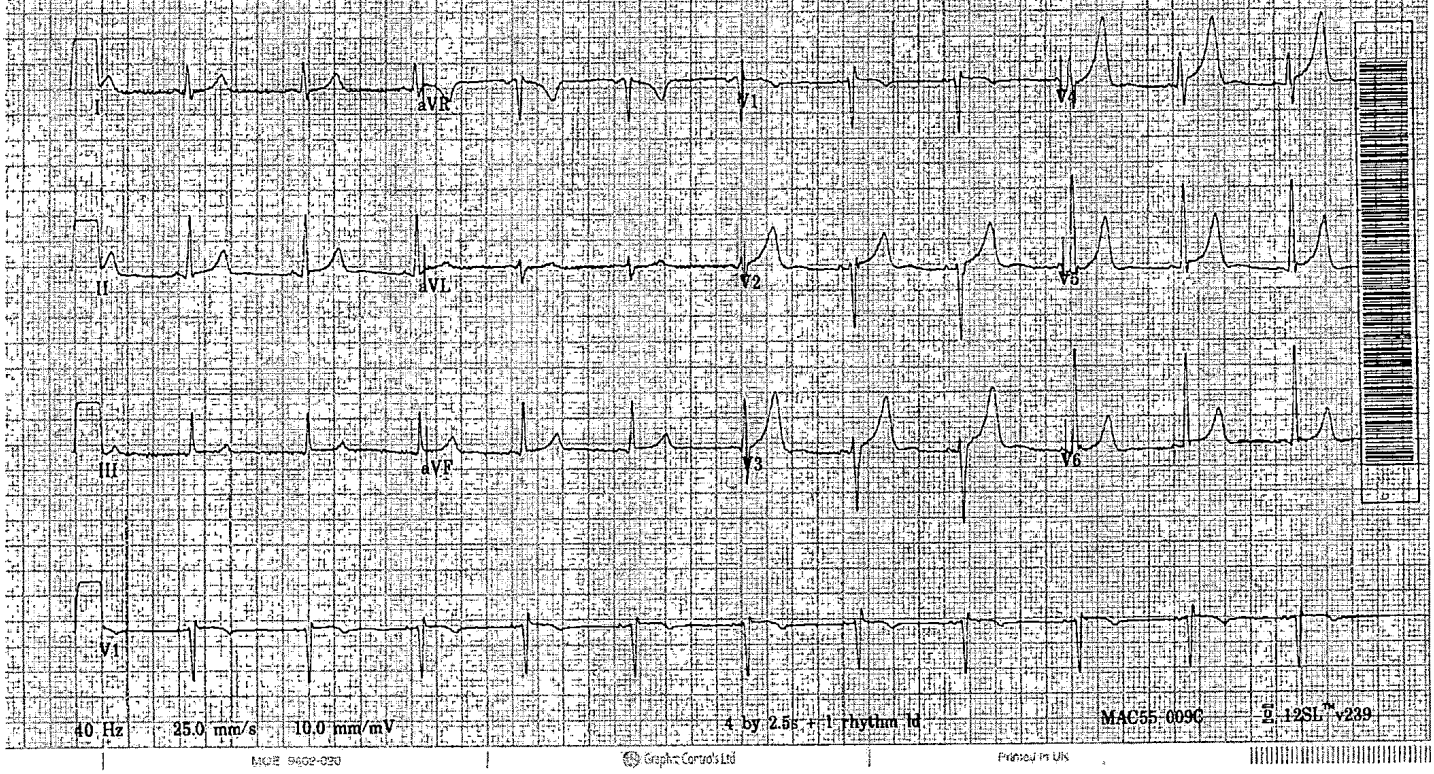
Technician: 834
Test ind:

Sinus rhythm with short PR
RSR' or QR pattern in V1 suggests right ventricular conduction delay
Early repolarization

1203893450
WEIR M
James 12/03/1989

Referred by:

Unconfirmed



40 Hz 25.0 mm/s 10.0 mm/mV 4 by 2.5s + 1 rhythm ld MAC55 009C 12SL v239

MOE 9402-020 Graphic Controls Ltd Printed in UK

WEIR, JAMES ID: 1203893450 24-Jul-2017 17. 4 RAH

12-Mar-1989
Male Caucasian
Room
Opt
Technician: 500
Test ind

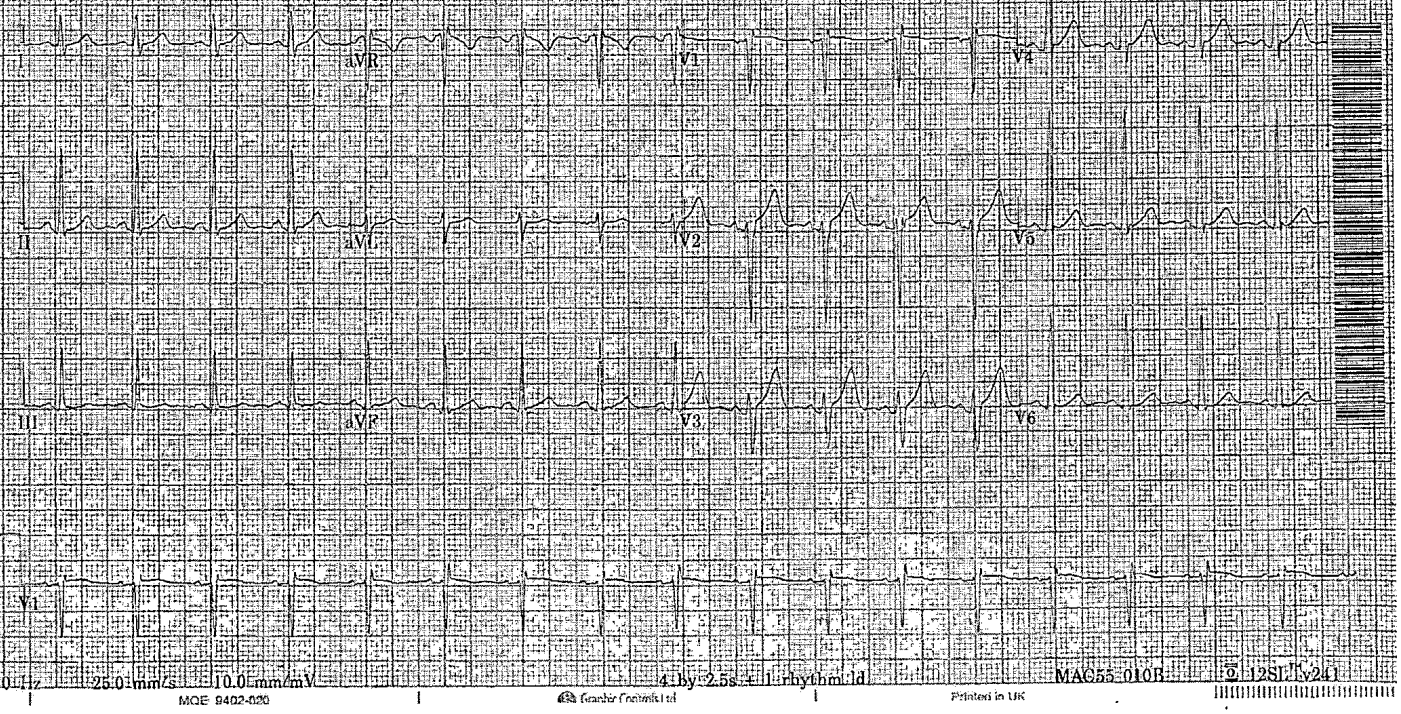
Vent. rate	105	bpm
PR interval	116	ms
QRS duration	84	ms
QT/QTc	322/425	ms
P-R-T axes	67 76 45	

Sinus tachycardia

1203893450
WEIR M
James 12/03/1989
27D MACDOWALL STREET
Johnstone, Renfrewshire
PA5 8QJ

Referred by:

Unconfirmed



40 Hz 25.0 mm/s 10.0 mm/mV 4 by 2.5s + 1 rhythm ld MAC55 010B 12SL v241

WEIR, JAMES ID: 1203893450 24-Jul-2017 17:[illegible] RAH

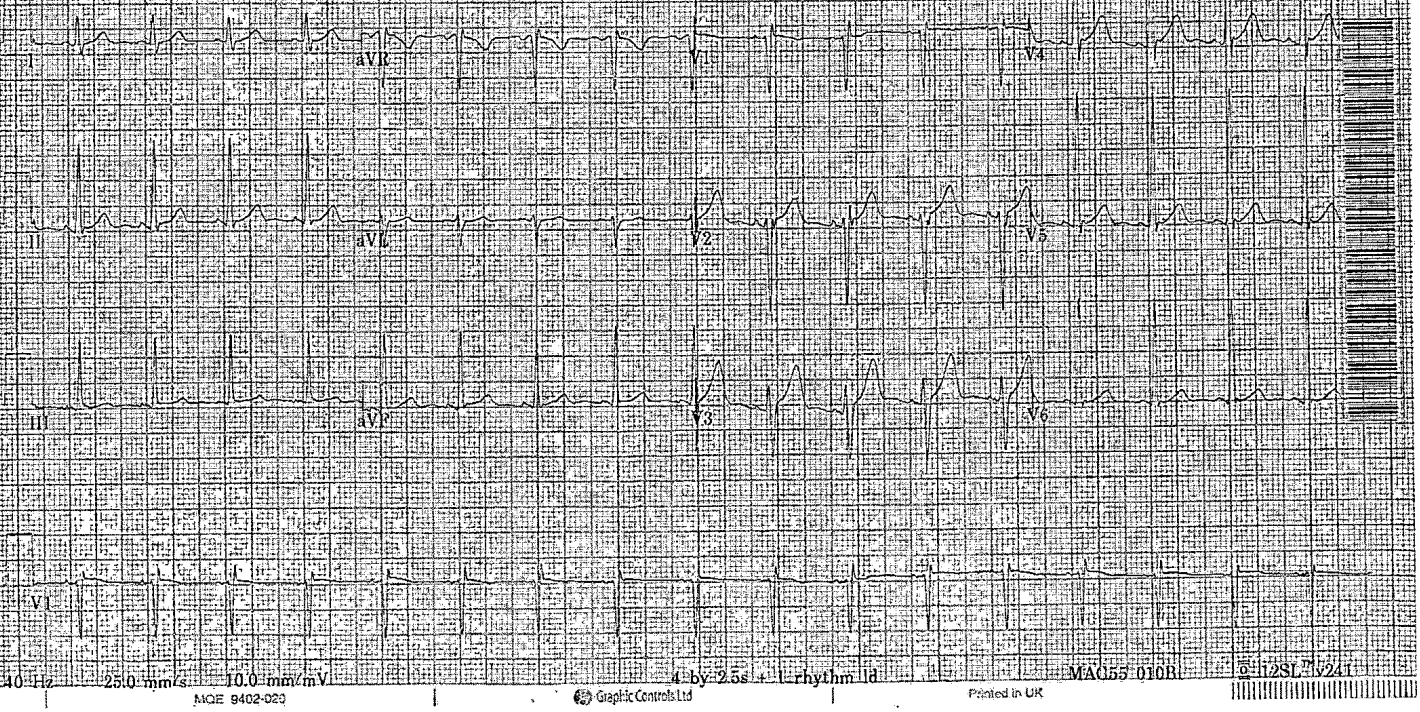
12-Mar-1989
Male Caucasian
Room
Opt:
Technician: 500
Test ind:

Vent. rate	104	bpm
PR interval	90	ms
QRS duration	78	ms
QT/QTc	314/412	ms
P-R-T axes	32 80 57	

Sinus tachycardia with short PR

Referred by:

Unconfirmed



10 Hz 25.0 mm/s 10.0 mm/mV 4 by 2.5s + 1 rhythm Id MAC55 010R 12SL v241

MQE 9402-020 Graphic Controls Ltd Printed in UK

XR Chest

Performed	08-Apr-2026 13:14	Received	26-Apr-2026 11:40
Reported	26-Apr-2026 11:38	Order Number	C418H43405927
Status	Final	Source System	MiSys

XR Chest Final
James Thomas Weir
Clinical History :
Worsening SOB ? cause. Ex smoker

XR Chest :
The heart is not enlarged. The lungs are clear of active disease. No significant focal lung lesion is identified.

Reported by: Dr Sean Kelly and None
Verified by: Dr Sean Kelly

XR Chest

Performed	12-May-2022 13:21	Received	26-May-2022 08:04
Reported	26-May-2022 08:02	Order Number	C418H38429160
Status	Final	Source System	MiSys

XR Chest Final
James Weir
Clinical History :

chest pain. ? lung pathology

XR Chest :
No discernible change compared to 5 years ago. No focal active lung or pleural disease demonstrated. Mediastinum normal.

Reported by: Dr Andrew Christie
Verified by: Dr Andrew Christie

XR Hand Lt

Performed	21-Apr-2022 15:47	Received	21-Apr-2022 16:44
Reported	21-Apr-2022 16:42	Order Number	C418H38358637
Status	Final	Source System	MiSys

XR Hand Lt Final
James Weir
Clinical History :
pt fell on glass yesterday wound to L thenar eminence ? FB in wound

XR Hand Lt :
No radiopaque foreign body demonstrated.
Artefact or bandage noted.

Code N: No note: No sticky note available. Referrer's interpretation is unknown.

Reported by: Dr Salwa Alwindi (SpR) and Katrina Kettlewell (Reporting Radiog)
Verified by: Katrina Kettlewell (Reporting Radiog)

XR Chest

Performed	24-Jul-2017 19:30	Received	25-Jul-2017 12:05
Reported	25-Jul-2017 12:03	Order Number	C418H32876526
Status	Final	Source System	MiSys

XR Chest Final
James Weir
Clinical History :

Increased shortness of breath cough chjest pain

XR Chest :
Normal heart mediastinal contours. Lungs are clear. Imaged bony thorax is normal.

Reported by: Dr Allison McCall
Verified by: Dr Allison McCall

XR Foot Rt

Performed	09-Jun-2017 06:16	Received	09-Jun-2017 10:15
Reported	09-Jun-2017 10:13	Order Number	C418H32731690
Status	Final	Source System	MiSys

XR Ankle Rt Final
James Weir
Clinical History :

Kicked door with instep R foot whilst at work yesterday. Since event c/o increased pain on mobilising. O/E swelling & bony tenderness medial malleolar zone & navicular R foot.

XR Ankle Rt :
Comparison made with study dated 01/09/2013. No bone or joint injury demonstrated.

XR Foot Rt :
No bone or joint injury demonstrated.

Reported by: Dr Sarah MacPherson (ST1)
Verified by: Dr Sarah MacPherson (ST1)

XR Ankle Rt

Performed	09-Jun-2017 06:16	Received	09-Jun-2017 10:15
Reported	09-Jun-2017 10:13	Order Number	C418H32731689
Status	Final	Source System	MiSys

XR Ankle Rt Final
James Weir
Clinical History :

Kicked door with instep R foot whilst at work yesterday. Since event c/o increased pain on mobilising. O/E swelling & bony tenderness medial malleolar zone & navicular R foot.

XR Ankle Rt :
Comparison made with study dated 01/09/2013. No bone or joint injury demonstrated.

XR Foot Rt :
No bone or joint injury demonstrated.

Reported by: Dr Sarah MacPherson (ST1)
Verified by: Dr Sarah MacPherson (ST1)

XR Chest

Performed	06-Jun-2017 10:19	Received	21-Jun-2017 08:27
Reported	21-Jun-2017 08:25	Order Number	C418H32719490
Status	Final	Source System	MiSys

XR Chest Final
James Weir
Clinical History :
Prominent cough haemoptysis.

XR Chest :
Normal heart mediastinal contours. Lungs are mildly hyperinflated but clear. Imaged bony thorax is normal.

Reported by: Dr Allison McCall
Verified by: Dr Allison McCall

XR Foot Rt

Performed	19-Sep-2016 12:26	Received	19-Sep-2016 14:50
Reported	19-Sep-2016 14:48	Order Number	C418H31859893
Status	Final	Source System	MiSys

XR Foot Rt Final
James Weir
Clinical History :
kicked heavy object. bruised base 3rd-5th MTs
(Information via Order Comms)

XR Foot Rt :
No fracture identified.

Reported by: Dr Orla Doyle (ST2)
Verified by: Dr Orla Doyle (ST2)

XR Knee Rt

Performed	03-Jun-2016 10:07	Received	10-Jun-2016 08:17
Reported	10-Jun-2016 08:15	Order Number	C418H31506470
Status	Final	Source System	MiSys

XR Knee Rt Final
James Weir
Clinical History :

XR Knee Rt :
Previous tibial screw fixation noted. No major complications. No significant change in appearance allowing for technical differences compared to 18/12/2009.

Reported by: Dr Sean Kelly
Verified by: Dr Sean Kelly

XR Chest

Performed	02-Jun-2016 14:03	Received	02-Jun-2016 15:55
Reported	02-Jun-2016 15:53	Order Number	C418H31503875
Status	Final	Source System	MiSys

XR Chest Final
James Weir
Clinical History :

Presents with chest pain and histopry of SOB, smokes cannabis. ?pneumothorax

XR Chest :
Normal cardiac, hilar and mediastinal contours. No focal active lung disease or cardiac decompensation.
No pneumothorax.

Reported by: Dr Trudy Coyle
Verified by: Dr Trudy Coyle

XR Hand Rt

Performed	16-Nov-2015 09:15	Received	16-Nov-2015 09:41
Reported	16-Nov-2015 09:41	Order Number	C418H30844360
Status	Final	Source System	MiSys

XR Hand Rt Final

James Weir

Fracture Clinic Follow-up: A radiological report will not be issued for this examination. The referrer (or a more experienced clinical colleague) will interpret and evaluate the outcome of this examination and document this outcome in the patient's case notes within an appropriate time-scale. **Employers procedure EP10 -Clinical Evaluation ,Ionising Radiation (Medical Exposure) Regulations IR(ME)R 2000.**

Reported by: Auto Reporting
Verified by: David Wilson

XR Hand Rt

Performed	03-Nov-2015 21:44	Received	04-Nov-2015 07:57
Reported	04-Nov-2015 07:55	Order Number	C418H30806535
Status	Final	Source System	MiSys

XR Hand Rt Final
James Weir
Clinical History :
punch injury tender base of 5th mc ?fracture

XR Hand Rt :
A lucency is seen at the base of the ring finger metacarpal consistent with a nondisplaced transverse fracture. No other injuries are identified.

Report by Jonathan McConnell consultant reporting radiographer.

Reported by: Jonathan McConnell
Verified by: Jonathan McConnell

XR Chest

Performed	01-Mar-2015 13:48	Received	02-Mar-2015 17:00
Reported	02-Mar-2015 16:58	Order Number	C418H30011111
Status	Final	Source System	MiSys

XR Chest Final
James Weir
Clinical History :

haematemesis and chest pain ?perf. Erect CXR please to look for free air

XR Chest :
Comparison has been made with previous study dated 03/12/2014.

The heart mediastinal contours are unremarkable. The lungs are clear. No change compared to previous. No free subdiaphragmatic gas.

Reported by: Dr Caroline Cameron
Verified by: Dr Caroline Cameron

XR Shoulder Lt

Performed	03-Dec-2014 21:26	Received	04-Dec-2014 12:53
Reported	04-Dec-2014 12:51	Order Number	C418H29734880
Status	Final	Source System	MiSys

XR Shoulder Lt Final
James Weir
Clinical History :
fall from quadbike, 50MPH, landed on back. reduced range of motion in left arm ?dislocationh ? fracture. Also chest pain worse on deep breathing ?rib fracture

fall from quadbike, 50MPH, landed on back. reduced range of motion in left arm ?dislocationh ? fracture. Also chest pain worse on deep breathing ?rib fracture
?PTX

XR Shoulder Lt :

No bone or joint injury in relation to the glenohumeral joint or proximal humerus.
At the AC joint there is slight loss of alignment at the under surfaces of the acromion relative to the clavicle. Appearances could represent a very minor grade 1 AC joint subluxation. No other bone or joint injury seen in relation to the clavicle or AC joint.

XR Chest :

Cardiac size and mediastinal contours are within normal limits.
Lungs are clear.
No pneumothorax identified.
The left cardiac border and left mediastinal contour edge looks quite sharp and it would be difficult to exclude subtle pneumomediastinum. Are there any clinical features to suggest this ?
The bony thorax itself appears grossly intact with no overt rib fracture identified.

Reported by: Dr Alan Wallace
Verified by: Dr Alan Wallace

XR Chest

Performed	03-Dec-2014 21:26	Received	04-Dec-2014 12:53
Reported	04-Dec-2014 12:51	Order Number	C418H29734881
Status	Final	Source System	MiSys

XR Shoulder Lt Final
James Weir
Clinical History :
fall from quadbike, 50MPH, landed on back. reduced range of motion in left arm ?dislocationh ? fracture. Also chest pain worse on deep breathing ?rib fracture

fall from quadbike, 50MPH, landed on back. reduced range of motion in left arm ?dislocationh ? fracture. Also chest pain worse on deep breathing ?rib fracture
?PTX

XR Shoulder Lt :

No bone or joint injury in relation to the glenohumeral joint or proximal humerus.
At the AC joint there is slight loss of alignment at the under surfaces of the acromion relative to the clavicle. Appearances could represent a very minor grade 1 AC joint subluxation. No other bone or joint injury seen in relation to the clavicle or AC joint.

XR Chest :

Cardiac size and mediastinal contours are within normal limits.
Lungs are clear.
No pneumothorax identified.
The left cardiac border and left mediastinal contour edge looks quite sharp and it would be difficult to exclude subtle pneumomediastinum. Are there any clinical features to suggest this ?
The bony thorax itself appears grossly intact with no overt rib fracture identified.

Reported by: Dr Alan Wallace
Verified by: Dr Alan Wallace

XR Chest

Performed	14-Aug-2014 03:32	Received	14-Aug-2014 12:05
Reported	14-Aug-2014 12:03	Order Number	C418H29365413
Status	Final	Source System	MiSys

XR Chest Final
James Weir
Clinical History :

vomitting and abdominal pain, ?perf

XR Chest :

Normal heart and mediastinum. Lungs are clear. There is no free subdiaphragmatic air.

Reported by: Dr Shalini Datta
Verified by: Dr Shalini Datta

XR Chest

Performed	26-Mar-2014 20:39	Received	14-Apr-2014 11:37
Reported	14-Apr-2014 11:35	Order Number	C418H28917981
Status	Final	Source System	MiSys

XR Chest Final
James Weir
Clinical History : Epigastric pain. Alcohol excess. Exclude perforation.

XR Chest :

Cardiac size and mediastinal contours are within normal limits. No focal active pulmonary disease or cardiac failure. No free subdiaphragmatic air.

Reported by: Dr Alan Wallace
Verified by: Dr Alan Wallace

XR Chest

Performed	02-Jan-2014 20:51	Received	03-Jan-2014 13:53
Reported	03-Jan-2014 13:51	Order Number	C418H28650762
Status	Final	Source System	MiSys

XR Chest Final
James Weir
Clinical History :
Haemoptysis. Smoker.

XR Chest :
Normal cardiomediastinal contours. The lungs are clear.

Reported by: Dr Shiva Koteeswaran
Verified by: Dr Shiva Koteeswaran

CT Urinary tract

Performed	15-Dec-2013 13:49	Received	15-Dec-2013 15:06
Reported	15-Dec-2013 15:04	Order Number	C418H28602123
Status	Final	Source System	MiSys

CT Urinary tract Final
James Weir
Clinical History :
4-day history of loin to groin pain. Frank haematuria. Renal stones?

CT Urinary tract :
Unenhanced axial CT. Interpretation is made difficult by the lack of intra-abdominal and pelvic fat.
No renal tract calcification identified. There is minor wall thickening of the proximal left ureter no adjacent inflammatory change. There is no hydronephrosis or hydroureter. Appearances could represent pyelonephritis.

There is a degree of faecal loading.
Within the limits of a noncontrast CT there are no further significant positive findings.

Reported by: Dr Trudy Coyle
Verified by: Dr Trudy Coyle

XR Abdomen

Performed	12-Dec-2013 23:39	Received	13-Dec-2013 10:49
Reported	13-Dec-2013 10:47	Order Number	C418H28600882
Status	Final	Source System	MiSys

XR Abdomen Final
James Weir
Clinical History :
Loin to groin pain and haematuria.

XR Abdomen :

Normal bowel gas pattern. No renal calcification is evident.

Reported by: Dr Shalini Datta
Verified by: Dr Shalini Datta

CT Head

Performed	06-Oct-2013 10:09	Received	06-Oct-2013 10:50
Reported	06-Oct-2013 10:28	Order Number	C418H28388010
Status	Final	Source System	MiSys

CT Head Final
James Weir
Clinical History :
History of alcohol excess. New onset seizures.

CT Head noncontrast:
Normal appearance of brain ventricular system. No intracranial pathology is demonstrated.
Normal appearance of the skull.

Reported by: Dr Christopher Smith
Verified by: Dr Christopher Smith

XR Knee Rt

Performed	01-Sep-2013 13:11	Received	05-Sep-2013 18:21
Reported	05-Sep-2013 17:59	Order Number	C418H28284580
Status	Final	Source System	MiSys

XR Ankle Rt Final
James Weir
Clinical History : Fall ? Fracture.

XR Ankle Rt :
No fracture.

XR Knee Rt :
Screw fixation of the proximal tibia from prior injury. No acute fracture.

Reported by: Dr Andrew Hunter
Verified by: Dr Andrew Hunter

XR Ankle Rt

Performed	01-Sep-2013 13:11	Received	05-Sep-2013 18:21
Reported	05-Sep-2013 17:59	Order Number	C418H28284579
Status	Final	Source System	MiSys

XR Ankle Rt Final
James Weir
Clinical History : Fall ? Fracture.

XR Ankle Rt :
No fracture.

XR Knee Rt :
Screw fixation of the proximal tibia from prior injury. No acute fracture.

Reported by: Dr Andrew Hunter
Verified by: Dr Andrew Hunter

XR Foot Rt

Performed	25-Apr-2013 21:54	Received	29-Apr-2013 09:33
Reported	26-Apr-2013 10:11	Order Number	C418H27902512
Status	Final	Source System	MiSys

XR Ankle Rt Final
James Weir
Clinical History :
Foot injury very tender generally medial malleolus and 4th and 5th metatarsal.

XR Ankle Rt :
Comparison is made to previous film of 07/03/2011. There is an avulsed fracture fragment at the tip of the medial malleolus.

XR Foot Rt :
No acute bony injury demonstrated.

Reported by: Dr Alfred Tan (SpR) and Dr Piotr Nowak
Verified by: Dr Alfred Tan (SpR)

XR Ankle Rt

Performed	25-Apr-2013 21:54	Received	29-Apr-2013 09:33
Reported	26-Apr-2013 10:11	Order Number	C418H27902511
Status	Final	Source System	MiSys

XR Ankle Rt Final
James Weir
Clinical History :
Foot injury very tender generally medial malleolus and 4th and 5th metatarsal.

XR Ankle Rt :
Comparison is made to previous film of 07/03/2011. There is an avulsed fracture fragment at the tip of the medial malleolus.

XR Foot Rt :
No acute bony injury demonstrated.

Reported by: Dr Alfred Tan (SpR) and Dr Piotr Nowak
Verified by: Dr Alfred Tan (SpR)

XR Chest

Performed	03-Oct-2012 04:02	Received	09-Oct-2012 14:03
Reported	09-Oct-2012 13:41	Order Number	C418H27307032
Status	Final	Source System	MiSys

XR Chest Final
James Weir
Clinical History :
Collapse.

XR Chest :
The heart is not enlarged. Lungs are clear. Normal mediastinum.

Reported by: Dr Shalini Datta
Verified by: Dr Shalini Datta

XR Foot Rt

Performed	07-Mar-2011 12:58	Received	07-Mar-2011 17:06
Reported	07-Mar-2011 16:42	Order Number	C418H25691848
Status	Final	Source System	MiSys

XR Foot Rt Final
James Weir
Clinical History : Foot went down pothole this morning causing inversion injury. Tender distal tibia and first metatarsal.

XR Foot Rt :
There is slight loss of alignment on the oblique view at the base of the third metatarsal with the lateral cuneiform. No definite fracture is identified but the possibility of a Lisfranc dislocation is raised. Orthopaedic review is suggested.

XR Ankle Rt :
No acute bone or joint injury demonstrated.

Provisional report telephoned to referring ENP.

Reported by: Dr Caroline Cameron
Verified by: Dr Caroline Cameron

XR Ankle Rt

Performed	07-Mar-2011 12:58	Received	07-Mar-2011 17:06
Reported	07-Mar-2011 16:42	Order Number	C418H25691849
Status	Final	Source System	MiSys

XR Foot Rt Final
James Weir
Clinical History : Foot went down pothole this morning causing inversion injury. Tender distal tibia and first metatarsal.

XR Foot Rt :
There is slight loss of alignment on the oblique view at the base of the third metatarsal with the lateral cuneiform. No definite fracture is identified but the possibility of a Lisfranc dislocation is raised. Orthopaedic review is suggested.

XR Ankle Rt :
No acute bone or joint injury demonstrated.

Provisional report telephoned to referring ENP.

Reported by: Dr Caroline Cameron
Verified by: Dr Caroline Cameron

XR Knee Rt

Performed	18-Dec-2009 14:22	Received	29-Dec-2009 11:18
Reported	29-Dec-2009 11:15	Order Number	C418H20920007
Status	Final	Source System	MiSys

XR Knee Rt Final
James Weir
Clinical History : .

XR Knee Rt : Two screws are demonstrated within the tibial plateau which appear in satisfactory position. A healing fracture of the proximal third of the fibula is also seen.

Reported by: Dr Jonathan Foley
Verified by: Dr Jonathan Foley

XR Knee Rt

Performed	23-Oct-2009 15:13	Received	27-Oct-2009 16:28
Reported	27-Oct-2009 16:28	Order Number	C418H20882636
Status	Final	Source System	MiSys

XR Knee Rt Final
James Weir
Clinical History : Tibial plateau fracture in cast brace after ORIF.

XR Knee Rt : Post-operative position seems satisfactory.

Reported by: Dr Neil Corrigan
Verified by: Dr Neil Corrigan

Orthopaedic pinning lower limb Rt

Performed	07-Oct-2009 14:00	Received	16-Oct-2009 09:11
Reported	16-Oct-2009 09:11	Order Number	C418H20871463
Status	Final	Source System	MiSys

Orthopaedic pinning lower limb Rt Final
James Weir
Theatre Check Films taken.
A radiological report will not be issued for this examination. The referrer (or a more experienced clinical colleague) will interpret and evaluate the outcome of this examination and document this outcome in the patient's case notes within an appropriate time-scale. Reference: Procedure 10, Evaluation of Medical Exposure, Ionising Radiation Medical Exposures Regulations IRM(E) R 00.

Reported by: Allison Ogg
Verified by: Allison Ogg

CT Knee Rt

Performed	30-Sep-2009 14:11	Received	30-Sep-2009 16:46
Reported	30-Sep-2009 16:41	Order Number	C418H20866193
Status	Final	Source System	MiSys

CT Knee Rt Final
James Weir
Clinical History : Fractured lateral tibial plateau ? anatomy of fracture. Swollen, painful knee. RTA. Valgus deformity.

CT Knee Rt : Spiral non-contrast acquisition.

There is a comminuted depressed fracture of the anterolateral tibial plateau with 4mm of depression of the fracture fragments. The fracture extends into the tibio-femoral joint. See films for position and appearance.

Reported by: Dr Marzi Davies
Verified by: Dr Marzi Davies

XR Cervical spine

Performed	30-Sep-2009 00:53	Received	30-Sep-2009 14:39
Reported	30-Sep-2009 14:35	Order Number	C418H20865973
Status	Final	Source System	MiSys

XR Cervical spine Final
James Weir
Clinical History : Cyclist knocked down by car. Trauma series extremities done earlier.

XR Cervical spine : There is normal vertebral body height and alignment. There is no evidence of soft tissue swelling and no evidence of acute bony injury.

XR Chest : Supine film. Rotated. Despite the projection, the heart is not enlarged. There is no evidence of active focal lung disease or cardiac decompensation.

Reported by: Dr Allison McCall
Verified by: Dr Allison McCall

XR Pelvis

Performed	29-Sep-2009 22:38	Received	30-Sep-2009 14:41
Reported	30-Sep-2009 14:38	Order Number	C418H20865956
Status	Final	Source System	MiSys

XR Pelvis Final
James Weir
Clinical History : Trauma (cyclist knocked down by car).

XR Pelvis &

XR Femur Rt : No obvious pelvic or upper femoral fracture. I presume there is no clinical suspicion of trauma at the symphysis pubis (slightly wide looking on this frontal view).

XR Tibia/Fibula (Lower Leg) Rt &

XR Knee Rt : At the knee there is a lipohaemarthrosis with a fracture of the lateral tibial plateau. There is additionally a fracture of the upper left fibula.

Reported by: Dr Patrick Walsh
Verified by: Dr Patrick Walsh

XRAY TYPE

Performed	22-Mar-2008 00:00	Received	25-Mar-2008 10:05
Reported	25-Mar-2008 00:00	Order Number	20397719
Status	Final	Source System	MiSys

XR Orthopantomogram Final
James Weir
Clinical History : Trauma.

XR Orthopantomogram : No bone injury seen.

XR Mandible : No bone injury seen.

Reported by: Dr Iain McGlinchey