

NHS Forth Valley

Carseview House
Castle Business Park
Stirling
FK9 4SW



Telephone: 01324 566292
Fax:

Private and Confidential

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

Date: 29 April 2026
Your Ref: 100106
Our Ref: GDP/0021239

Enquiries to: Legal Admin Team
Extension:
Direct Line: 01324 566292

Dear Sir/Madam

Re: Gary Scrimshaw

With reference to your recent access request please find enclosed copy health records as requested.

Please note that records held by Forth Valley Royal Hospital will include records for Falkirk Community Hospital and Stirling Health & Care Village.

If we can be of any further assistance then please do not hesitate to contact us.

Yours Sincerely

A handwritten signature in black ink, appearing to be 'MMA', written over a horizontal line.

Legal Admin Team

E-mail: fv.healthrecs-legal@nhs.scot

NHS Forth Valley
Headquarters: Carseview House, Castle Business Park, Stirling, FK9 4SW

nhsforthvalley.com [/nhsforthvalley](https://www.facebook.com/nhsforthvalley)
 [@nhsforthvalley](https://twitter.com/nhsforthvalley) [@nhsforthvalley](https://www.instagram.com/nhsforthvalley)



Date of attendance: 20/05/2024 22:04
 Presenting complaint: chest pain (Sas wr)

Surname: Scrimshaw Address: 40 Johnston Crescent Tillicoultry Clackmannanshire Telephone: 07340830479 Date of Birth: 30/11/1979	Forename: Gary Postcode: FK13 6PZ Sex: Male	Title: Mr CHI: 3011795258 Age: 44 Years
GP Name: G Campbell Address: 25544/1 Tillicoultry Medical Practice Park Street Tillicoultry Tillicoultry FK13 6AG	Telephone: 01259 750531	
Next of Kin Name: Tracey Scrimshaw Relationship: Wife Address: 40 Johnston Crescent Tillicoultry Clackmannanshire		
Postcode: FK13 6PZ Telephone: 07423556817		
Triage Information chest pain R sided chest pain, stabbing in nature, non radiating, clammy, sweaty - denies pain at triage, no cardiac hx recent problem		
Observations P= 63 BP= 124 / 67 RR= 17 Sat= 97 BM= Temp= 36.6 Peak Flow= GCS= News= 0		

Emergency Department / Pre-Hospital Drugs				Allergies			
Date	Drug	Dose	Route	Signature	Given by	Time	

DNW

PVC INSERTION BUNDLE AND REMOVAL RECORD

PLEASE COMPLETE ALL BOXES

The patient's skin is decontaminated and allowed to dry YES / NO
 Hand hygiene & gloves donned prior to insertion YES / NO
 Aseptic Non-Touch Technique is used to insert PVC YES / NO
 If not possible, use either STERILE GLOVES or MINI CHLORAPREP
 Sterile dressing & sticker (date & time) applied after insertion YES / NO

GARY SCRIMSHAW
 PATIENT LABEL
300795258

Why is PVC clinically indicated for patient?: (please tick)

IV Fluids: Blood Transfusion
 IV Drugs Diagnostics
 Predicted clinical need

Colour: _____
 Insertion Site: _____
 Ward/Department: _____
 Inserted by: _____
 Date & Time: _____
 Removed: YES / NO

INVESTIGATIONS

Bloods Required:
 FBC U&E GLU LFT CRP AMY CLOTTING G&S ESR PARACETAMOL
 TROP D-DIMER CULTURES VBG* ABG* (*attach to notes) URINALYSIS HCG ECG
 Others: _____
 BLOODS TAKEN? YES / NO TIME TAKEN **20:00**
 SIGN **[Signature]**
 PRINT **[Signature]**

Preliminary Pressure Ulcer Risk Assessment (PPURA):

Mobility: Person is fully mobile without equipment/assistance Points to Consider
 Contenance: Person is fully continent * People who are overweight may not be well nourished
 Nutrition: Person appears well nourished and able to eat and drink * Use of repositioning mattress or pressure relieving heel
 Skin: Skin to pressure points satisfactory/intact protectors.

Record your answer in the grid below Y = Yes or N = No
 If the answer is NO to any assessments undertake a BRADEN and consider any other assessment

DATE	TIME	MOBILITY	CONTINENCE	NUTRITION	SKIN INSPECTED	SKIN INTACT	BRADEN COMPLETED	SIGNATURE
SKIN DESCRIPTION i.e. REDNESS, SKIN BROKEN, BLISTER / ULCER						ACTION TAKEN		

4AT

ALERTNESS (assess for drowsiness or agitation, if asleep attempt to rouse)		Tick
Normal	0	
Mild sleepiness (easily roused <10 seconds)	0	
Clearly abnormal	4	
AMT4 (age, date of birth, place, current year)		Tick
No mistakes	0	
1 mistake	1	
2 or more mistakes	2	
ATTENTION (ask for months of the year backwards)		Tick
Achieves 7 or more correctly	0	
Starts but scores less than 7/Refuses to start	1	
Untestable	2	
ACUTE CHANGE OR FLUCTUATION (significant change incl. evidence of psychotic symptoms)		Tick
No	0	
Yes	4	
Total score (score of 4 or more indicates likely delirium - initiate TIME bundle)		

FALLS TRIGGER TOOL (Complete only if 65 years or over)

2 or more falls in the last 6 months? YES / NO Tries to walk alone and is unsteady? YES / NO
 Fall since admission to department? YES / NO Patient/relatives anxious about falls YES / NO
 Admitted to department with fall? YES / NO 4AT more than 4/evidence of confusion YES / NO
 COMPLETED BY _____

If you have answered yes to 2 or more questions,
 • For patients being admitted please document recommendation that a full care bundle is required to be completed.
 • Please add FALLS RISK IDENTIFIER to Trakcare (EPR -> Patient Alerts -> New -> Ward Signifiers -> Falls risk).

020204

Booked Number: CR01031114

Patient Information

GARY SCRIMSHAW

Age/Gender: 44 years 5 months 21 days Old Male

Address: 90 Johnston Cr.
TULLICULTRY

DOB: 30/11/1979

CHI: 3011785258

Ethnicity: White Scottish

FK13 6PZ

Date: 20/05/2024

Incident Number: CR010341114

Incident Type: EMG

Incident Location: NEW BREWERY
KELLIEBANK ALLOA,
FK10 1NU



Presenting Complaint

AS1 44YOM CHEST PAIN

Additional Comments

O/a alert and orientated gcs15. At work. hpc - since 1400 has been having intermittent chest pain at rest. Episodes lasting 10-15 mins each time, started at rest, radiates to right arm and down to fingers. Has been feeling nauseated and clammy. Also feels SOB during these episodes. Worsening whilst at work tonight called ambulance then. O/e - obs as charted. Chest clear, 12 lead ecg sinus rhythm with what appears to be an rsr pattern on v1 and v2. given aspirin and gtn. Pain score was 6/10 with sas, was worse before sas arrival. After gtn pain reduced to a 1/10. unknown if family hx of heart problems as grown up through care system. Shx - lives with wife, smoker, no alcohol intake. transported to frh for assessment. nok - tracey - 07423556817.

PATIENT ASSESSMENT

ACVPU Alert: <C> No

A Clear

B Breathing Adequately

Yes

Respiratory Rate 20

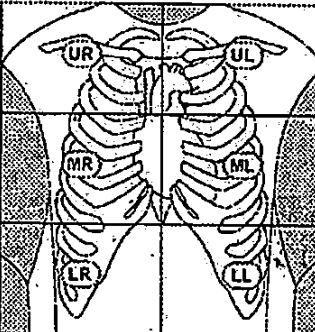
SPO2

97

Oxygen Given No

Normal Percussion, Normal Breath Sounds, Normal Air Entry

UR



Normal Percussion, Normal Breath Sounds, Normal Air Entry

UL

Normal Percussion, Normal Breath Sounds, Normal Air Entry

MR

Normal Percussion, Normal Breath Sounds, Normal Air Entry

ML

Normal Percussion, Normal Breath Sounds, Normal Air Entry

LR

Normal Percussion, Normal Breath Sounds, Normal Air Entry

LL

C Pulse Rate: 85 BP: 146/94 Cap Refill: <=2 Secs ECG Rhythm: Sinus Rhythm

Rhythm: Reg

Arm: Right

Central/Peripheral: Peripheral

ECG: 12 Lead

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

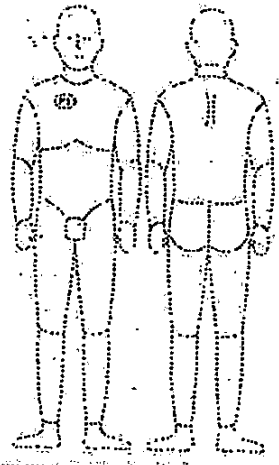
E



THIS IS A RECONSTITUTED DOCUMENT PRINTED FROM 

52224

Invoice Number: CR01031114



Pain		
ID	Body Part	Pain Scale
P1	Chest	6

Observations															
Time	P	RR	BP	SpO2	CR	GCS	ACVPU	ETCO2	T	BM	ECG	P(L)	P(R)	PEF	CrawID
21:38	72	18	120/64	97	<=2s	15	Alert								E0000196
21:13	85	20	146/84	97	<=2 Secs	15	Alert		36.8	B	Sinus Rhythm				E9886581

NEWS2									
Time	RR	SpO2 Scale 1	SpO2 Scale 2	Air/O2	BP	P	ACVPU	T	Total
21:13	20 (0)	97 (0)		0	146 (0)	85 (0)	Alert (0)	36.8 (0)	0

Drugs								
Time	Drug	Dosage	Units	Route	Drug Expiry Date	Pain Before	Pain After	CrawID
21:30	Aspirin	300	mg	OR	06/2025			E0000196
21:32	GTN	800	mcg	SL	06/2026	6	3	E0000196

HISTORY	
AMPLE	
Allergies	None
Medication	SEE ECS
Past Medical History	SHERMANS DISEASE (BACK CURVATURE, BACK INJURY)
Last Eaten	>4 Hours Ago
Events Prior	CHEST PAIN INTERMITTENT SINCE 1400, WORSENING

Social History			
Lives alone	No	Living With	WIFE
Patient Occupation		Factory Occupation	FACTORY WORKER
Patients General Appearance	Normal		
Living Arrangement	Dependants		
Patient Mobility	Fully Mobile		
Patient Communication	No Help Required		
Patient Clinical Risk Factors	Smoker		
Patient Environmental Risk Factors	None Identified		



THIS IS A RECONSTITUTED DOCUMENT PRINTED FROM EDRM

622204

Incident Number: CP01001114

Site	RIGHT SIDE	Onset	1400 ONWARDS
Character	TIGHT STABBING, Intermittent, Worsening	Radiated	Yes, RIGHT ARM TO FINGER TIPS
Associated Symptoms	CLAMMY, Nausea	Timing	LASTS 10-15 MINS EACH EPISODE
Exacerbating Or Relieving Symptoms	GTN HELPED.	Severity	6/10

Safeguarding

Safeguarding Assessment Adult >= 16

MEDICAL

ACS

Associated Symptoms Breathlessness

CLOSE RECORD

Treatment On Scene Non-Emergency

Conveyance

Transport To Hospital Normal driving Pre-Alert No

INCIDENT LOG

Time Call Received	20:48	Allocated	20:49	Mobile	20:49
First Resource On Scene		Crew On Scene	21:04	Crew Left Scene	21:32
Crew At Hosp	21:51	Receiving Hospital	FORTH VALLEY ROYAL HOSPITAL		Clear Time

Crew ID	Crew Grade	Driver
E0000198	Paramedic	YES
E9886581	Paramedic	NO

Emergency Discharge Letter (Authorised)

G Campbell
Tillicoultry Medical Practice
Park Street
Tillicoultry
Tillicoultry
FK13 6AG

FVRH Emergency Department
Stirling Road
Larbert
Larbert
Stirlingshire
FK5 4WR
Dept. Contact Details:

CHI Barcode:



3011795258

Date of Completion: 21-May-2024

GP Practice

GP Name:	G Campbell	GP GMC:	7277373
GP Practice Address:		GP Practice Code:	7277373/25544
		GP Clinic Code:	25544
		GP Telephone:	

Patient Demographics

Patient Name:	SCRIMSHAW, Gary	Date Of Birth:	30-Nov-1979
Patient Address:	40 Johnston Crescent Tillicoultry Clackmannanshire FK13 6PZ	Gender:	Male
Telephone No:	07340830479	CHI No:	3011795258

Admission Details

Patient Location:	FVRH Emergency Department	Admission Date:	20-May-2024
Admission Care Provider:	Dr Ainsley Heyworth	Admission Time:	22:04
Source Of Admission:	999 Emergency Services		

Presenting Complaint

chest pain (Sas wr)

Diagnosis

Diagnosis	Site	Laterality
ED diagnosis - Left before clinical assessment		

Procedures

No Procedure Results

Medications

Nil records exist

Discharge Details

Discharge Type:	Admitted	Discharge Date:	21-May-2024
Discharge Destination:	Admission to same NHS healthcare provider / hospital - Medical Ward	Discharge Time:	03:01
Referred To:			

Notes for GP

Person completing record

Authorised by

Name:

Designation or role:

Specialty:

Date completed:

21-May-2024

Clinically completed by

Name:

Designation or role:

Specialty:

Distribution List

Recipient Name

G Campbell

Recipient Type

GP

Recipient Organisation

Tillicoultry Medical Practice

Immediate Discharge Letter (Authorised)

G Campbell
Tillicoultry Medical Practice
Park Street
Tillicoultry
Tillicoultry
FK13 6AG

Acute Medicine
Stirling Road
Larbert
Larbert
Stirlingshire
FK5 4WR

Dept. Contact Details:

CHI Barcode:



3011795258

Date of Completion: 21-May-2024

Patient Demographics

Patient Name:	SCRIMSHAW, Gary	Date Of Birth:	30-Nov-1979
Patient Address:	40 Johnston Crescent Tillicoultry Clackmannanshire FK13 6PZ	Gender:	Male
Telephone No:	07340830479	CHI No:	3011795258

GP Practice

GP Name:	G Campbell	GP GMC:	7277373
GP Practice Address:		GP Practice Code:	7277373/25544
		GP Clinic Code:	25544
		GP Telephone:	

Admission Details

Patient Location:	Acute Medicine	Admission Care Provider:	Dr Daniel Beckett
Admission Date:	21-May-2024	Admission Time:	15:11
Admission Method:	Emergency Admission, no additional detail added	Ward:	FVRH UCC SDEC
Source Of Admission:	GP Non Obstetrics - other Provider		

Discharge Details

Discharge Specialty:	Acute Medicine	Discharge Care Provider:	Dr Daniel Beckett
Discharge Date:	21-May-2024	Ward:	FVRH UCC SDEC
Discharge Time:	16:49	Discharge Destination:	Private Residence - no additional detail added
Discharge Method:	Regular discharge, no additional detail added		

Clinical Summary including History

Dear Dr,

Gary attended RACU with 1/52 history of chest tightness and SOB intermittent in nature. Non exertional. Describes episode yesterday severe with associated clamminess with palpitations whilst at work. No cough/ feversh symptoms/ nausea.

Obs/ BP 131/82 rr 54 rr 16 O2 98% ra. temp 36.3C

OE/ pulse reg HS I+II+O chest clear

ECG nsr

CXR nad

Bloods checked in ED 20/5 no change in presentation normal FBC, UES, LFTs, troponin. D dimer checked today normal.

Imp/MSK injury / stress

Plan/
Home with worsening statement

Should you require any further information please contact RACU.

Kind regards, Dr Catriona Parker, GPWSI acute medicine

Safety Alerts

Nil records exist

Allergy/Intolerance

Allergy records are as recorded at time and date of printing

Nil records exist

Medications**Drug Information:**

Drug	Dose	Route	Frequency	GP to Continue	POD	Days Supply
------	------	-------	-----------	----------------	-----	-------------

Nil records exist

Drug Notes:

Drug	Drug Notes
------	------------

Nil records exist

Additional Medicine Information:

Medicines discontinued during admission (Medicines that patient was recorded as admitted on only)

Drug	Discontinued Reason
------	---------------------

Nil records exist

GP Communications:**Outstanding Results****Responsibility of Hospital**

Nil records exist

Person completing record**Authorised by**Name:
Designation or role:
Specialty:
Date completed: 21-May-2024**Clinically completed by**Name:
Designation or role:
Specialty:**Distribution List**

Recipient Name	Recipient Type	Recipient Organisation
G Campbell	GP	Tillcoultry Medical Practice

Emergency Discharge Letter (Authorised)

AE Kolle
Tillicoultry Medical Practice
Park Street
Tillicoultry
Tillicoultry
FK13 6AG

FVRH Emergency Department
Stirling Road
Larbert
Larbert
Stirlingshire
FK5 4WR

Dept. Contact Details:

CHI Barcode:



3011795258

Date of Completion: 27-May-2021

GP Practice			
GP Name:	AE Kolle	GP GMC:	4269506
GP Practice Address:	Tillicoultry Medical Practice Park Street Tillicoultry Tillicoultry FK13 6AG	GP Practice Code:	4269506/25544
		GP Clinic Code:	25544/1
		GP Telephone:	01259 750531

Patient Demographics			
Patient Name:	SCRIMSHAW, Gary	Date Of Birth:	30-Nov-1979
Patient Address:	40 Johnston Crescent Tillicoultry Clackmannanshire FK13 6PZ	Gender:	Male
		CHI No:	3011795258
Telephone No:	07340830479		

Admission Details			
Patient Location:	FVRH Emergency Department	Admission Date:	26-May-2021
Admission Care Provider:	Dr Laura Muir	Admission Time:	12:07
Source Of Admission:	Self referral		

Presenting Complaint	
r knee inj	

Diagnosis		
Diagnosis	Site	Laterality
ED diagnosis - Redirection - ED nurse redirection (as per policy)		

Procedures	
No Procedure Results	

Medications	
Nil records exist	

Discharge Details			
Discharge Type:	With follow up	Discharge Date:	26-May-2021
Discharge Destination:	Private Residence - Usual place of residence	Discharge Time:	12:24

Referred To:

Notes for GP

referred to UCC for L knee inj, app time 1230

Person completing record

Name:	Dr Emma Elliott	Specialty:	
Designation or role:	Consultant	Date completed:	27-May-2021

Distribution List

Recipient Name	Recipient Type	Recipient Organisation
AE Kelle	GP	Tillicoultry Medical Practice

Emergency Discharge Letter (Authorised)

AE Kolle
Tillicoultry Medical Practice
Park Street
Tillicoultry
Tillicoultry
FK13 6AG

FVRH Urgent Care Centre
Stirling Road
Larbert
Larbert
Stirlingshire
FK5 4WR

Dept. Contact Details:

CHI Barcode:



3011795258

Date of Completion: 26-May-2021

GP Practice			
GP Name:	AE Kolle	GP GMC:	4269506
GP Practice Address:	Tillicoultry Medical Practice Park Street Tillicoultry Tillicoultry FK13 6AG	GP Practice Code:	4269506/25544
		GP Clinic Code:	25544/1
		GP Telephone:	01259 750531

Patient Demographics			
Patient Name:	SCRIMSHAW, Gary	Date Of Birth:	30-Nov-1979
Patient Address:	40 Johnston Crescent Tillicoultry Clackmannanshire FK13 6PZ	Gender:	Male
		CHI No:	3011795258
Telephone No:	07340830479		

Admission Details			
Patient Location:	FVRH Urgent Care Centre	Admission Date:	26-May-2021
Admission Care Provider:	Urgent Care Centre Clinician	Admission Time:	12:27
Source Of Admission:	Self referral		

Presenting Complaint	
Right leg inj appt 12.30	

Diagnosis		
Diagnosis	Site	Laterality
ED injury - soft tissue - Other Soft tissue injury		

Procedures	
No Procedure Results	

Medications	
Nil records exist	

Discharge Details			
Discharge Type:	With no follow up	Discharge Date:	26-May-2021
Discharge Destination:	Private Residence - Usual place of residence	Discharge Time:	13:27

Referred To:

Notes for GP

1. P/C -Right knee injury

Brought in on wheelchair. Attends with wife. Normally independant. Works in Brewery

2. H/P/C -Standing on equipment at work, part of machinery gave way, foot slipped and right lower leg slipped between gap in metal machinery suspending pt by right knee about 11am today. Ongoing knee pain and abrasions to knee. Applied ice at time

3. Relevant PMH/Meds - Back pain Meds - Amytriptyline, Co-codamol 30/500 NKDA

4. O/E - Superficial wound to medial aspect right knee, 2x superficial/partial thickness abrasions/wounds to lateral aspect right knee. Woundbed visible, no FB/underlying structures, no discharge, no signs of infection. No NV deficit. CRT <2secs. No obvious swelling or bruising to knee. No deformity. No effusion. No popliteal swelling. Tender over medial aspect right knee. No bone tenderness foot, ankle, fibia, tibia, fibular head, tibial tuberosity, tibial plateau, lateral condyls, patella, femur. FROM of ankle no pain. Able to straight leg raise. Able to fully extend - but with pain. Active flexion 165 degrees, L=R=N, but with pain. ACL, PCL, LCL, MCL intact, no laxity or increased pain on resisted testing. Pt able to independantly mobilise around department

5. Ix -

6. Dx -Soft tissue injury right knee

7. Tx -Wounds cleaned and dressed with siloflex and mepore dressings. Wound and dressing advice given. Given knee injury advice sheet. Advised mobilise knee ++ as able. Advised regular analgesia. Advised to monitor for signs of infection.

8. Plan -Discharge.If signs of infection or ongoing concerns return G,P or NHS 24

9. GP note -

Person completing record

Name:	Ms Catriona Quirk	Specialty:	
Designation or role:	Emergency Nurse Practitioner	Date completed:	26-May-2021

Distribution List

Recipient Name	Recipient Type	Recipient Organisation
AE Kollé	GP	Tillicoultry Medical Practice

Dr Andreas Kolle
Tillicoultry Medical Practice
Park Street
Tillicoultry
FK13 6AG

Date Dictated 16 November 2020
Date Typed 16 November 2020

Our Ref XA//3011795258
CHI 3011795258

Discharge Summary

Dear Dr Kolle

Gary Scrimshaw 30/11/1979
40 Johnston Crescent Tillicoultry Clackmannanshire FK13 6PZ

Diagnosis: Right shoulder pain after falling from road bike

Outcome

- | | |
|-------------------------------------|--|
| <input type="checkbox"/> | Much better / Problem resolved |
| <input type="checkbox"/> | Improved |
| <input type="checkbox"/> | No change |
| <input type="checkbox"/> | Worse |
| <input checked="" type="checkbox"/> | Patient did not complete course of treatment |
| <input type="checkbox"/> | Patient did not attend initial appointment |
| <input type="checkbox"/> | Patient failed to respond to offer of appointment letter |
| <input type="checkbox"/> | Patient declined initial appointment |

Additional Comments:

Number of sessions: 1 (telephone)

Pain started after a bike fall on 30/09/2020. Patient reported decreased movement due to pain.

Attended A&E - X-ray (no fracture, but showed tendon calcification). I offered him a face to face consultation. Unfortunately, he did not attend this appointment and has not contacted the department since. Therefore, outcome is unknown.

Yours sincerely

(Electronically checked by Xabier Ariztegieta)

Chair: Jamie McCusker
Chief Executive: Cathie Cowan

Forth Valley NHS Board is the common name for Forth Valley Health Board
Registered Office: Carslaw House, Castle Business Park, Stirling, FK9 4SW

www.nhsforthvalley.com  Facebook.com/nhsforthvalley  @nhsforthvalley



INVESTORS
IN PEOPLE

Gold
Until 2021

Xabier Ariztegieta
HCPC Registered Physiotherapist

For NHS Forth Valley physiotherapy appointments and queries contact the AHP MSK Hub on 01324
673890 or FV-UHB.AHPMSKHub@nhs.net

Emergency Discharge Letter (Authorised)

AE Kollé
Tillicoultry Medical Practice
Park Street
Tillicoultry
Tillicoultry
FK13 6AG

SCH Minor Injuries
Livlands Gate
Stirling
Stirling
Stirlingshire
FK8 2AU

Dept. Contact Details:

CHI Barcode:



Date of Completion: 02-Oct-2020

GP Practice

GP Name:	AE Kollé	GP GMC:	4269506
GP Practice Address:	Tillicoultry Medical Practice Park Street Tillicoultry Tillicoultry FK13 6AG	GP Practice Code:	4269506/25544
		GP Clinic Code:	25544/1
		GP Telephone:	01259 750531

Patient Demographics

Patient Name:	SCRIMSHAW, Gary	Date Of Birth:	30-Nov-1979
Patient Address:	40 Johnston Crescent Tillicoultry Clackmannanshire FK13 6PZ	Gender:	Male
		CHI No:	3011795258
Telephone No:	07340830479		

Admission Details

Patient Location:	SCH Minor Injuries	Admission Date:	02-Oct-2020
Admission Care Provider:	Dr Joanne Mitchell	Admission Time:	10:14
Source Of Admission:	Not Known		

Presenting Complaint

r shoulder inj

Diagnosis

Diagnosis	Site	Laterality
Calcific Tendinitis of Shoulder		

Procedures

No Procedure Results

Medications

Nil records exist

Discharge Details

Discharge Type:	With referral	Discharge Date:	02-Oct-2020
Discharge Destination:	Private Residence - Usual place of residence	Discharge Time:	13:17

Referred To: Physiotherapy

Notes for GP

PC: Right shoulder injury.

HPC: Fall from bike hitting bollard. Pain in right shoulder since. Already has pain in shoulder since previous fall. No head injury.

PMH: Nil

Symptoms: Pain anterior right shoulder. No altered neuro

OE: No obvious swelling, erythema, bruising, deformity.

Neck NAD

Shoulder- flex 90, Abd 90 LR full. Pain with hand behind back.

MP 5/5 with pain on abd and LR.

Drop arm -ve

NV intact.

X-RAY: No # seen. RC calcification.

Treatment: Collar and cuff. 1 - 2 days. Shoulder advice sheet.

Plan: Physio

GP Action: Nil

Person completing record

Name:	Specialty:
Designation or role:	Date completed: 02-Oct-2020

Distribution List

Recipient Name	Recipient Type	Recipient Organisation
AE Kelle	GP	Tillicoultry Medical Practice

Hospital use only	Clinic	Day Date	Time	Hospital No.
-------------------	--------	----------	------	--------------

Date Referral Submitted
(This date is fixed at hospital end);
08-Sep-2020

REFERRAL LETTER
MEDICAL IN
CONFIDENCE

3011795258

CHI No: 3011795258

101021629631U

Unique Care Pathway Number: 101021629631U

REFERRAL TO	
Physiotherapy - MusculoskeletalR5V5 FV Physio - Musculoskeletal	2 — Consultant / receiving practitioner and/or specialty clinic
Forth Valley Royal Hospital Stirling Road Larbert FK5 4WR	2 — Hospital and hospital address
	Hospital location code: V217H
Urgency of Referral Routine Physiotherapy - General Musculoskeletal Referral??	
Administrative Information	
Patient has special requirements: No	
Ethnic Origin: (White) British	

PATIENT DETAILS	
Surname Scrimshaw	Patient's address 40 Johnstone Crescent Tillicoultry FK13 6PZ
Forename(s) Gary	
Title -	
Sex Male	
Previous Surname -	
Date of birth 30-Nov-1979	Contact number(s)
CHI no. 3011795258	Voice: 07340830479 E-mail: garyscrimshaw@gmail.com

REFERRING PRACTITIONER DETAILS	
Name: Dr. Andreas Kelle (GMC: 4269506)	Practice address:
Practice: Tillicoultry Medical Practice (25544)	Park Street
Phone: Voice: 01259 750531	Tillicoultry
	FK13 6AG

CLINICAL INFORMATION

History of presenting complaint / examination findings / investigation results

Presenting Complaint

Description: Assessment.

Comment: This 40 year old gentleman works in a factory filling bottles. He has a 4 month history of a painful right shoulder. He points to the regimental badge area on the top of the shoulder, at the back as well. He has limited arc, being able to elevate the arm sideways up to 80 degrees and is unable really to move to a position if he wanted to pour out bottle.

I would be grateful for your further assessment and advice. He asked for some exercises to do and I gave him a link to NHS.inform - musculo skeletal zone to start with. He is already on Co-codamol and Amitriptyline for back problems and I have added some Naproxen today.

Thank you very much.

Kind regards.

Dr A E Kolle
Typed 08.09.2020 - FG

Examinations and Investigations

Murmur present: Not Recorded -
Is a 12 lead ECG: Not done -
Recent CXR: Not done -
FBC: Not Recorded -
Urea and Electrolytes: Not Recorded -
LFT: Not Recorded -
TFT: Not Recorded -
Lipid Profile: Not Recorded -
Glucose: Not Recorded -
Known risks: None -

Patient Measurements

Diastolic	Systolic	Height	Weight	BMI	Date Recorded
109	60				17-Aug-2010

Reason for referral

Care type requested: Out Patient
Expected outcome: Investigate

Medical history

Pre-existing Conditions (High Priority)

Description	?? Laterality	?? Modifier	?? Extension	?? Date Started	??
[X]Heroin addiction	?? -	?? -	?? PRIORITY=1	?? 26-May-2004	??

Past Procedures (High priority)

Description	?? Laterality	?? Extension	?? Date Recorded
Medication commenced for pain	?? -	?? -	?? 23-Feb-2010
New medication added	?? -	?? -	?? 20-Oct-2008

Active Repeat Therapy

Some Repeats may be Active but not Issued. In these instances, the Date Last Issued field contains the date authorised by the GP.

Drug name	?? Drug code	?? Formulation	?? Dosage	?? Frequency	?? Last Issued	??
Naproxen Tablets 500 mg	?? 1001010P0AAAEE	?? 56 tablet	?? ONE TO BE TAKEN TWICE A DAY	?? -	?? -	?? -
Co-Codamol 30/500 Tablets	?? 0407010F0AAAH	?? 3*24 TABLET	?? TWO TO BE TAKEN UP TO A MAXIMUM OF FOUR TIMES A DAY WHEN REQUIRED FOR PAIN	?? -	?? -	?? -
Amitriptyline Hydrochloride Tablets 25 mg	?? 0403010B0AAAH	?? 3*84 TABLET	?? ONE TABLET ONCE TO THREE TIMES A DAY DEPENDING ON SEVERITY	?? -	?? -	?? -

Issued Scripts for Acutes and Inactive Repeats (in last 90 days)

No recent medications recorded

Clinical warnings

Smoking status: Number per day: ? (not known)

Description	Comment	Date Recorded
Cigarette smoker, 20 Cigarettes/day		26-Jul-2018
Cigarette smoker	Smoking status on date of event: Y	06-Apr-2009

Alcohol status: Units per day: ? (not known)

Exercise status: Not Known

Allergies

<u>Description</u>	<u>?? Comment</u>	<u>?? Modifier</u>	<u>?? Start Date</u>	<u>?? Recorded Date</u>
Adverse reaction to Tramadol Hydrochloride	?? -	?? -	?? -	?? -

Additional relevant information
?

Signature of referring doctor (or other professional)	Date	08-Sep-2020
--	-------------	-------------

Dr David Borland
Dr Borland & Partners Cchc
Hallpark Road
Sauchie
FK10 3JQ

Date Dictated
Date Typed 16 March 2018
Our Ref: PR/3011795258
CHI: 3011795258

Discharge Summary

Dear Dr Borland

GARY SCRIMSHAW 30/11/1979
96 TENACRES SAUCHIE ALLOA FK10 3DP

Diagnosis: Chronic back pain

Outcome

- | | |
|-------------------------------------|--|
| <input type="checkbox"/> | Much better / Problem resolved |
| <input type="checkbox"/> | Improved |
| <input type="checkbox"/> | No change |
| <input type="checkbox"/> | Worse |
| <input checked="" type="checkbox"/> | Patient did not complete course of treatment |
| <input type="checkbox"/> | Patient did not attend initial appointment |
| <input type="checkbox"/> | Patient failed to respond to offer of appointment letter |
| <input type="checkbox"/> | Patient declined initial appointment |

Additional Comments:

Gary attended with a 22 year history of chronic back pain. He was given chronic pain advice, exercises and we discussed strategies to manage his pain better. He did not attend his review appointment and has not been back in touch.

Yours sincerely

(Electronically checked by Peter Reid)

Peter Reid



Chairman: Alex Linkston CBE
Chief Executive: Cathie Cowan

Forth Valley NHS Board is the common name for Forth Valley Health Board
Registered Office: Carseview House, Castle Business Park, Stirling, FK9 4SW

www.nhsforthvalley.com  [Facebook.com/nhsforthvalley](https://www.facebook.com/nhsforthvalley)  [@nhsforthvalley](mailto:nhsforthvalley@nhsforthvalley.com)

HCPC Registered Physiotherapist

For NHS Forth Valley physiotherapy appointments and queries contact the AHP MSK Hub on 01324
673890 or FV-UHB.AHPMSkHub@nhs.net

Hospital use only	Clinic	Day Date	Time	Hospital No.
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Date Referral Submitted
(This date is fixed at hospital end):
10-Jan-2018

REFERRAL LETTER
MEDICAL IN
CONFIDENCE

3011795258

CHI No: 3011795258

101015223314Z

Unique Care Pathway Number: 101015223314Z

REFERRAL TO	
Physiotherapy - Musculoskeletal R5V5 FV Physio - Musculoskeletal	Consultant / receiving practitioner and/or specialty clinic
Forth Valley Royal Hospital Stirling Road Larbert FK5 4WR	Hospital and hospital address Hospital location code: V217H
Urgency of Referral: Routine Physiotherapy - General Musculoskeletal Referral??	
Administrative Information Patient has special requirements: No Ethnic Origin: White Scottish	

PATIENT DETAILS	
Surname: Scrimshaw	Patient's address: 96 Ten Acres Sauchie Alloa FK10 3DP
Forename(s): Gary	
Title: - Sex: Male	Contact number(s): Voice: 07341940869 E-mail: garyscrimshaw@gmail.com
Previous Surname: -	
Date of birth: 30-Nov-1979	
CHI no: 3011795258	

REFERRING PRACTITIONER DETAILS	
Name: Dr. Catriona Lamb (GMC: 2956464)	Practice address: Hallpark Road Sauchie FK10 3JQ
Practice: Dr Borland & Partners CCHC (25031)	
Phone: Voice: 01259 216701	

CLINICAL INFORMATION

History of presenting complaint / examination findings / investigation results

Presenting Complaint

Description: Query

Comment: Dear Team,

This gentleman has had ongoing back problems for some considerable time. They seem to be of a mechanical nature having presented to me in May 2017 having overstretched at work causing acute back spasms.

He has been taking Amitriptyline and Co-codamol for some considerable time and was keen to try and come off them however he does suffer significant back pain when does stop his medication.

He was referred to your service in 2015 but failed to respond to offer of an appointment.

His problems date from his time in the Army and the symptoms can vary from left lumbar pain (2015 this caused numbness).

There are no current red flags but I suspect this gentleman needs some general education regarding chronic back pain. Thank you for considering seeing him.

Yours sincerely,

Dr. Catriona B Lamb

Examinations and Investigations

Murmur present: Not Recorded -
Is a 12 lead ECG: Not done -
Recent CXR: Not done -
FBC: Not Recorded -
Urea and Electrolytes: Not Recorded -
LFT: Not Recorded -
TFT: Not Recorded -
Lipid Profile: Not Recorded -
Glucose: Not Recorded -
Known risks: None -

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Medical history

Active Repeat Therapy

Some Repeats may be Active but not Issued. In these instances, the Date Last Issued field contains the date authorised by the GP.

Drug name	?? Drug code	?? Formulation	?? Dosage	?? Frequency	?? Last Issued
Amitriptyline Hydrochloride Tablets 25 mg	?? 0403010B0AAAH	?? 168 TABLET	?? 3 Daily	?? -	?? -

Issued Scripts for Acutes and Inactive Repeats (in last 90 days)

No recent medications recorded

Clinical warnings

Lifestyle risks

Exercise status: Not Known

Smoking status

Not Known

Alcohol consumption

Units per day
?? (not known)

Additional relevant information

?

Signature of referring doctor (or other professional)

Date

10-Jan-2018



NHS Forth Valley Radiology Report

Patient Name:	Scrimshaw, Gary (Mr)	Exam Date:	21/05/2024
Patient ID:	3011795258	Consultant:	BECKETT DR DANIEL CONS MEDIC
Patient Date of Birth:	30/11/1979	Report Date and Time:	22/05/2024 12:54:32
Patient Address:	40 JOHNSTON CRESCENT TILlicOUNTRY CLACKMANNANSHIRE FK13 6PZ	Referring Dept/Location:	FV RACU MEDICAL

Accession: V213936463501, Examination Date: 21/05/2024, Examination: XR Chest:

Indication:

Clinical Details:

increasing SOB and chest tightness

Provisional Diagnosis:

?pe

Findings:

PA chest:

Comparison is made with chest radiographs dated 20/08/2010.

Cardiomediastinal contours are within normal limits.

Lungs and pleural spaces are clear.

No focal areas of consolidation or collapse.

No pleural effusion.

Unremarkable bony thorax.

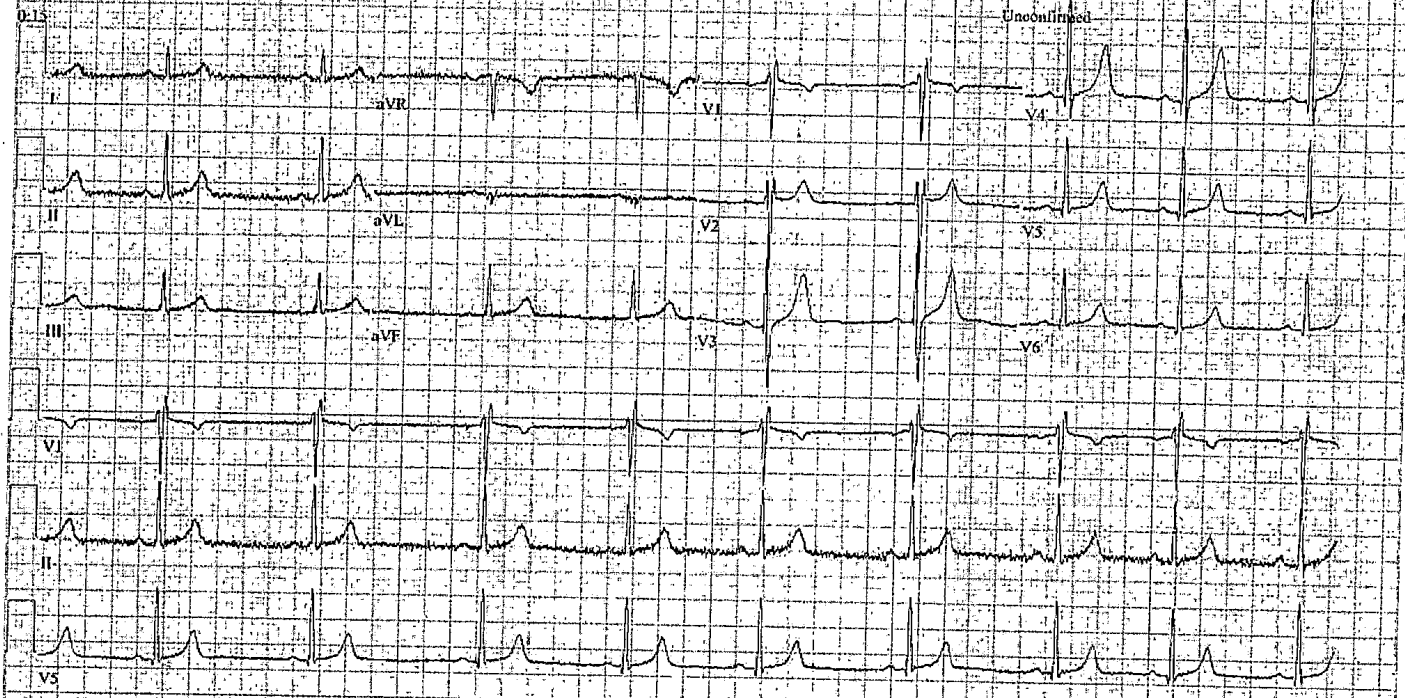
No radiographic evidence of active pulmonary disease.

Final Report By: Jonathan Mayers Reporting Radiographer HGPC RA78096 at 22/05/2024 12:54:32
Email Address: jonathan.mayers@nhs.scot

Scrimshaw, Gary	ID: 3011795258	21 MAY 2024 15:17:42	FORTH VALLEY HOSPITAL UCC ROUTINE RECORD
30 NOV 1979 (44 yr)	Vent. rate: 54 BPM	SINUS BRADYCARDIA WITH SINUS ARRHYTHMIA	
Male	PR Interval: 160 ms	POSSIBLE RIGHT VENTRICULAR CONDUCTION DELAY [RSR (OR) IN V1/V2]	
Room:	QRS duration: 98 ms	BORDERLINE ECG	
Loc: 15	QT/QTc: 408/388 ms	UNCONFIRMED REPORT	
	P-R-T axes: 44 66 64		

Technician:
Test Ind:

Unconfirmed



25mm/s 10mm/mV 50Hz 9.0.7 CID: 65535 SID: 1594661 EID: EDT: ORDER Page 1 of 1

THIS IS A RECONSTITUTED DOCUMENT PRINTED FROM EDRM

Last: Scrimshaw
First: Gary
ID: 3011795258
DOB: 30-Nov-1979
Age: 44yr
Comment:
Tech:
Ref Phys:

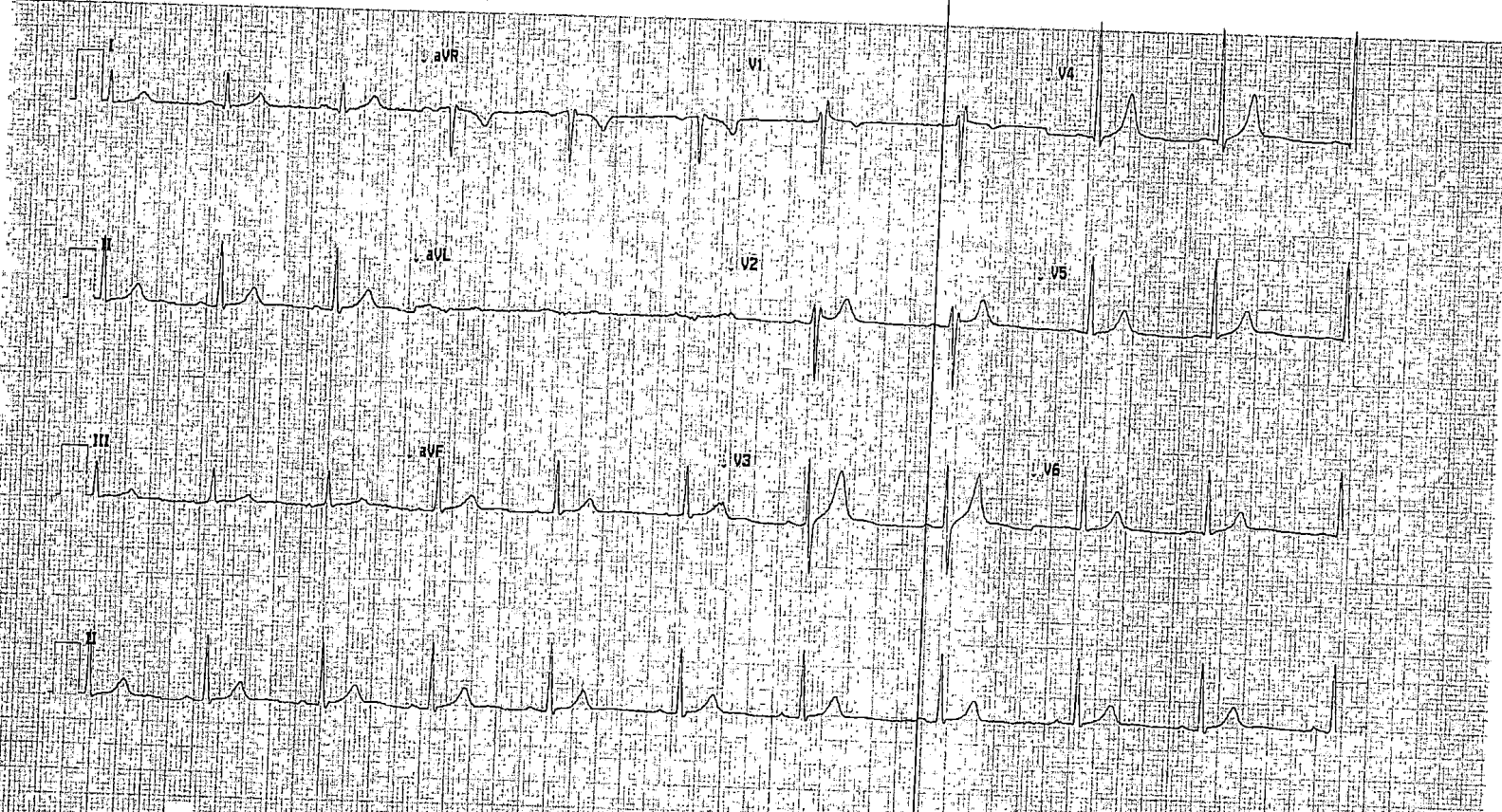
Sex: Male

20-May-2024 21:19

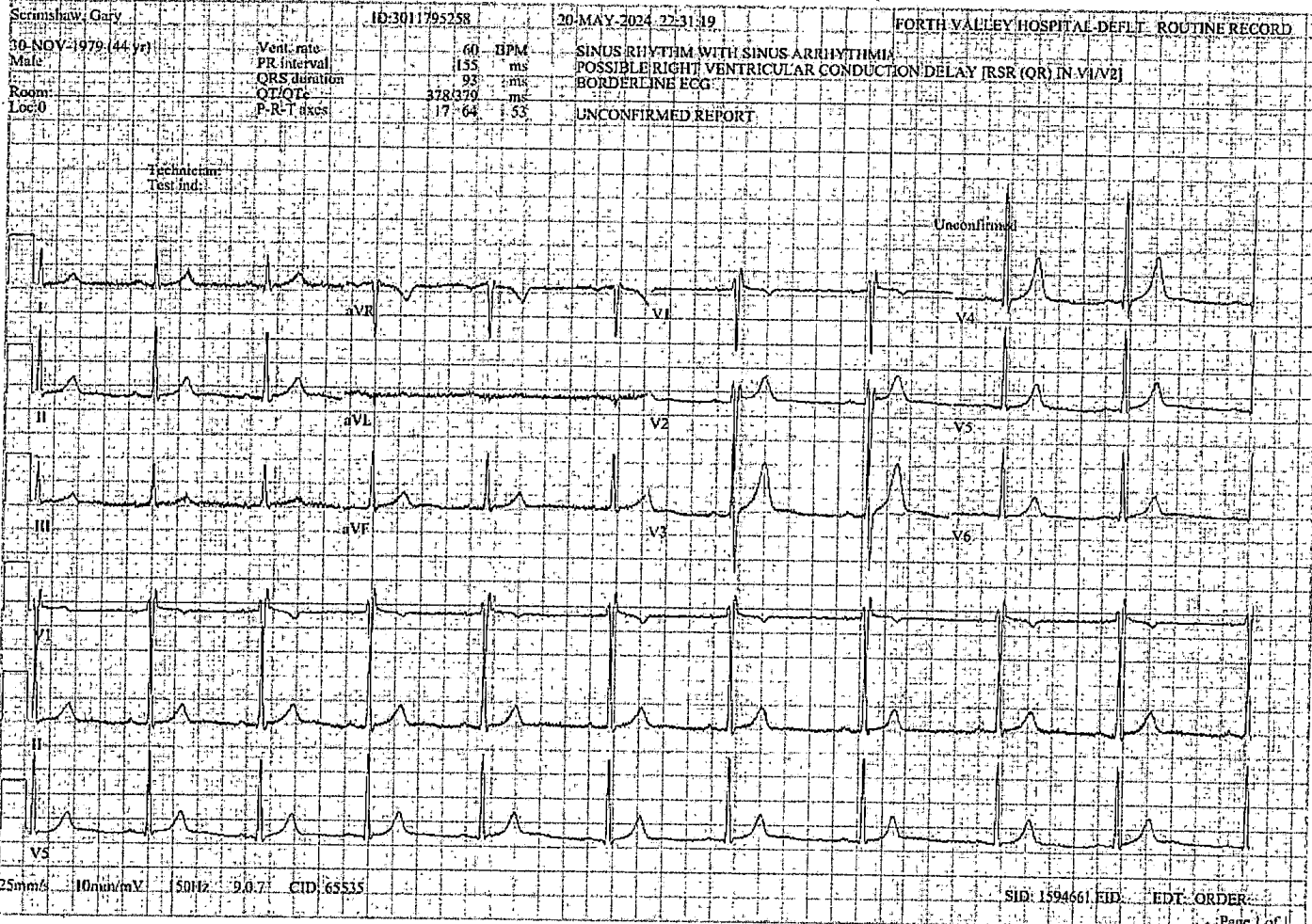
Vent rate 60 BPM
PR int 155 ms
QRS dur 93 ms
QT/QTc 378/378 ms
P-R-T axes 17 64 53

SINUS RHYTHM WITH SINUS ARRHYTHMIA
POSSIBLE RIGHT VENTRICULAR CONDUCTION DELAY (RSR (QR) IN V1/V2)
BORDERLINE ECG

UNCONFIRMED REPORT



11706053888 THIS IS A RECONSTITUTED DOCUMENT PRINTED FROM EDRM 2327



THIS IS A RECONSTITUTED DOCUMENT PRINTED FROM EDRM

Medication Administration Profile

Patient: Scrimshaw, Gary
Hospital No: 3011795258
Date of Birth: 30-Nov-1979
Allergies: ***Unknown***

National No: 301 179 5258

Weight: kg
Height: cm
Body Surface: m²

Date of Report: 20-Apr-2026 at 14:27 Page 1 of 1

Type of Report: Since Admission

Requested By: JRAE2

Current Status: Discharged

Admitted On: 21-May-2024

Discharged On: 21-May-2024

Sensitivities:

Episode History:

Consultant: DR DANIEL BECKETT

Transfer History:

Admitted to Ward: UCC SDEC (FVRH)

from 21-May-2024 15:11 to 21-May-2024 16:50

on 21-May-2024 at 15:11

There are no active medications for this patient.

CCHC

S/237397

L/S 7/Jan

Hospital use only | Clinic

Hospital No.

SCANNED *31/1/80t 10:15*
 APPT DETAILS *Debr Reid*
 PHYSIO.....
 LOCATION *CCHC*

Date Referral Submitted
 (This date is fixed at hospital end)
 10-Jan-2018

3011795258

TU1015223314Z*

Unique Care Pathway Number: 101015223314Z

REFERRAL TO

Physiotherapy - Musculoskeletal R5V5
 FV Physio - Musculoskeletal

Firth Valley Royal Hospital
 Stirling Road
 Larbert
 FK5 4WR

Consultant / receiving practitioner and/or specialty clinic
 Hospital and hospital address
 Hospital location code: V217H

Urgency of Referral: **Routine Physiotherapy - General** *11/1/18 LC*
Musculoskeletal Referral *veteran - send letter out*

Administrative Information
 Patient has special requirements: No
 Ethnic Origin: White Scottish

PATIENT DETAILS

Surname: Scrimshaw
 Forename(s): Gary
 Title: - Sex: Male
 Previous Surname: -
 Date of birth: 30-Nov-1979
 CHI no.: 3011795258

Patient's address
 96 Ten Acres
 Sauchie
 Alloa
 FK10 3DP

Contact number(s)
 Voice: 07341940869 / 07511670402
 E-mail: garyscrimshaw@gmail.com

REFERRING PRACTITIONER DETAILS

Name: Dr. Catriona Lamb (GMC: 2956464)
 Practice: Dr Borland & Partners CCHC (25031)
 Phone: Voice: 01259 216701

Practice address:
 Hallpark Road
 Sauchie
 FK10 3JQ

DLC on 6/2/18

CLINICAL INFORMATION

History of presenting complaint / examination findings / investigation results

Presenting Complaint

Description: Query

Comment: Dear Team,

This gentleman has had ongoing back problems for some considerable time. They seem to be of a mechanical nature having presented to me in May 2017 having overstretched at work causing acute back spasm.

He has been taking Amitriptyline and Co-codamol for some considerable time and was keen to try and come off them however he does suffer significant back pain when does stop his medication.

He was referred to your service in 2015 but failed to respond to offer of an appointment.

His problems date from his time in the Army and the symptoms can vary from left lumbar pain (2015 this caused numbness).

There are no current red flags but I suspect this gentleman needs some general education regarding chronic back pain. Thank you for considering seeing him.

Yours sincerely,

Dr Catriona B Lamb

Examinations and Investigations

Murmur present: Not Recorded -
 Is a 12 lead ECG: Not done -
 Recent CXR: Not done -
 FBC: Not Recorded -
 Urea and Electrolytes: Not Recorded -
 LFT: Not Recorded -
 TFT: Not Recorded -
 Lipid Profile: Not Recorded -
 Glucose: Not Recorded -
 Known risks: None

Patient Measurements

<u>Diastolic</u>	<u>Systolic</u>	<u>Height</u>	<u>Weight</u>	<u>BMI</u>	<u>Date Recorded</u>
120	70				13-Jan-2011
110	70				30-Jun-2006
110	70				30-Jun-2006
		169	67.55	23.65	13-Jan-2011
		171	64		30-Jun-2006

Reason for referral

Care type requested: Out Patient
 Expected outcome: Not Specified

Medical history

Active Repeat Therapy

Some Repeats may be Active but not Issued. In these instances, the Date Last Issued field contains the date authorised by the GP.

<u>Drug name</u>	<u>Drug code</u>	<u>Formulation</u>	<u>Dosage</u>	<u>Frequency</u>	<u>Last Issued</u>
Amitriptyline Hydrochloride Tablets 25 mg	0403010B0AAAH.AH.	168-TABLET	3 Daily		

Issued Scripts for Acutes and Inactive Repeats (In last 90 days)

No recent medications recorded

Clinical warnings

Smoking status: Number per day: ? (not known)

<u>Description</u>	<u>Comment</u>	<u>Date Recorded</u>
Current smoker		29-Dec-2017
Current smoker		03-Jul-2015
Current smoker		24-Sep-2013
Trying to give up smoking		13-Jan-2011
Cigarette smoker, 10 Cigarettes/day -		13-Jan-2011
Alcohol status:		
	Units per day: ? (not known)	
<u>Description</u>	<u>Comment</u>	<u>Date Recorded</u>
Alcohol consumption, 0 units/week	-	13-Jan-2011
Teetotaler	Disease: SPICE Basic Health Values, priority=2	30-Jun-2006
Exercise status:		
	Not Known	
<u>Description</u>	<u>Comment</u>	<u>Date Recorded</u>
Aerobic exercise 0 times/week	-	13-Jan-2011
Enjoys moderate exercise	Disease: SPICE Basic Health Values, priority=2	30-Jun-2006
Additional relevant information		

Signature of referring doctor (or other professional)	Date	10-Jan-2018
---	------	-------------

Screening Assessment

Patient's Name: Gary Scrimshaw CHI/DOB: 3011795258 Page: 4
Date: 31/01/18

General Health	Aligns
Investigations	Nil
Hospital Appts	Nil
PMH	Nil of note
Drug History	Co-codamol

✓ = No problem, X = Problem identified, N/A = Not applicable to patient, Do not leave blanks

Number of Red Flags	Health Parameters	✓/X/NA	Comments
■ ■ ■ / ■ ■ ■ ■ ■	Age 11-19 / <10 >55		
■ ■ ■ ■ ■	Ca/FHX of Ca	✓	
■ ■ ■ ■ ■ / ■ ■ ■ ■ ■ / ■ ■ ■	Weight loss >10% / 5-10% / <5%		
	Statins	✓	
	Diabetes	✓	
	Epilepsy	✓	
	Cardiovascular	✓	
	Blood Pressure	✓	
	Previous Strokes / TIA	✓	
	Respiratory / Asthma	✓	
■ ■ ■	Persistent Cough	✓	
■ ■ ■	Infection / Fevers / Viruses	✓	
■ ■ ■ ■ ■	HIV / Drug abuse	✓	
■ ■ ■ ■ ■	Night Sweating / Severe Pain	✓	
	Anticoagulants	✓	
■ ■ ■	Thoracic Pain	✓	
	Steroid Use / Osteoporosis	✓	
	RA / FHX of RA	✓	
	Other Joint Pain	✓	
	Allergies - Latex - Elastoplast	✓	

Physiotherapist Name: Peter Lynch - Student PT Signature: Peter Lynch

Alan P200 (B6PT)

Number of Red Flags	Health Parameters	✓/X/NA	Comments
	LUMBAR SPINE		
■ ■	Bladder / Bowel	✓	
■ ■ ■	Saddle Anaesthesia	✓	
	Cough / Sneeze	✓	
■ ■ ■	Cord Signs	✓	
■ ■	Inability To Lie Supine	✓	
	CERVICAL SPINE		
■	Dizziness		/
■	Diplopia		
■	Dysphagia		
■	Dysphasia		
■	Drop Attacks		
■ ■ ■	Cord Signs		
	PERIPHERAL JOINTS		
	Locking		
	Giving Way		
	Immediate Swelling		

Yellow Flags	Comments
Worries/Anxieties	Not Paralytic. Learned to live with it.
Perceptions	Muscular.
Quality of Life	↓ QoL. Limbs atrophies

Blue Flags	Comments
Currently Off Work	Please Circle: Yes <u>(No)</u> N/A
Time Off	
What Changes will Allow You To Work?	

Shared Goals	Date Set	Target Date	Barriers	Achieved Y/N
Manage P/Blow - w/S.	3/16/18			

Physiotherapist Name: Peter Lynch - Student PT Signature: Peter Lynch

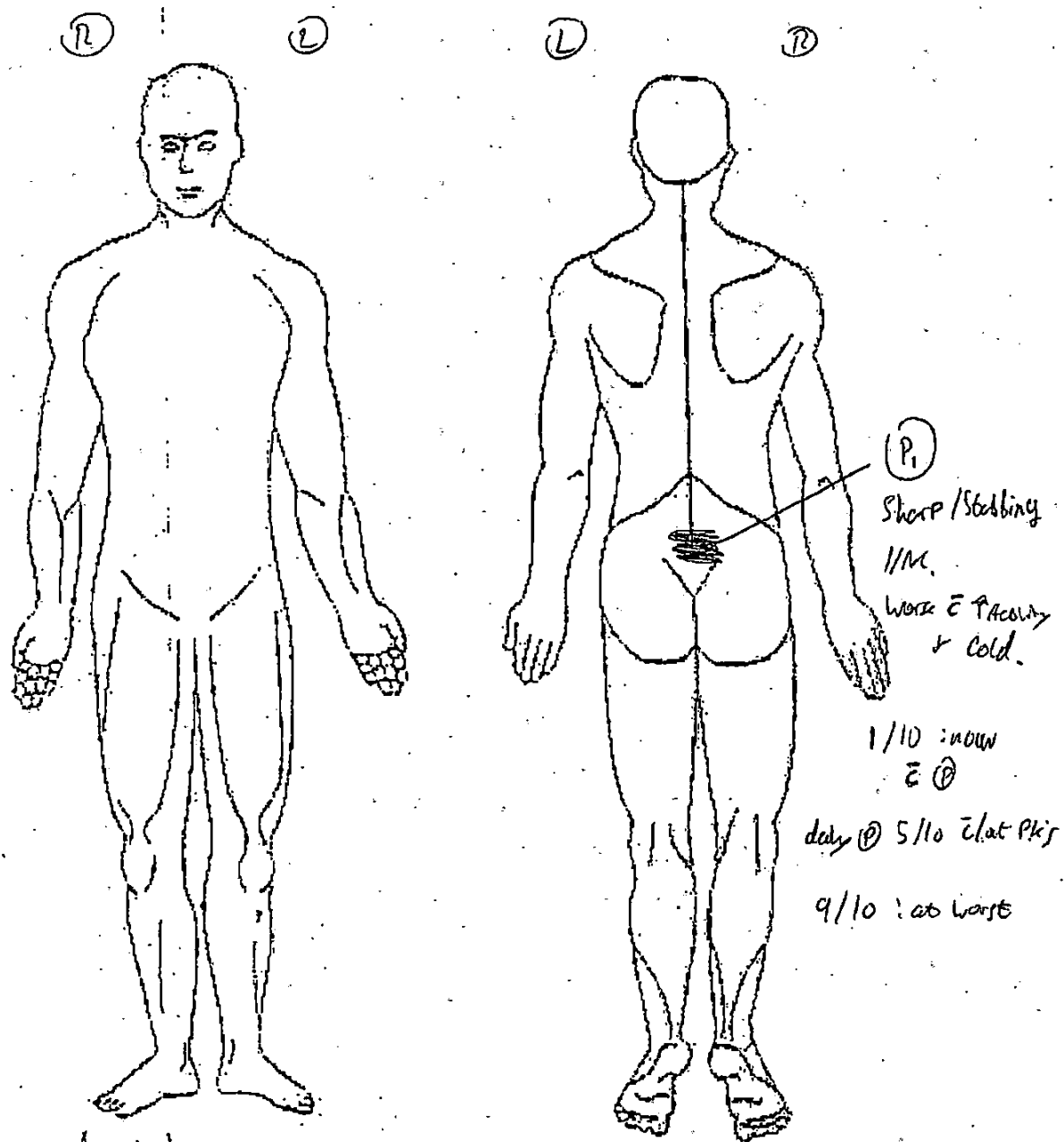
Name: Gary Scrimshaw CHI 3011795258

Date: 31/01/18

Page No. 6

Aggs: • Cold weather
• Bending forward / twisting / rotate

Triggers: • Sitting & legs arched & pressure underneath.
"Taking arch out of back"



24 hour Pattern: A.m: depends on activity. P @ & P activity.
P.m: depends on activity. P @ & P activity.
Nights: Disturb sleep wakes up couple times in night. Trying to get comfortable.

Physiotherapist Name: Peter Lynch - Student PT Signature: Peter Lynch

Alan P. [Signature]

Name Gary Scrimshaw

CHI 3011795258

S/E: Date 31/01/18

Page No. 7

P.C. Back (P)

H.P.C. 22/11 ago. In army. Carrying weights on back. Collected one day.

Was running/braking, stretched away. Sudden onset of (P) in Lx. Had 2/6 riggles in previous training but this event was very painful. Army PTs said Pt had ↑ Lx lordosis which predisposed problem.

SoHo Missing Scans. NAD. ↑ lordosis caused "stress fractures". Tried swimming, heat, yoga poses, etc, nothing really helped.

- Lives in UK + was (C3 + 11)
- Amazon. In warehouse. Always on feet picking orders. 10 hr shifts.
- Cycling, mountain biking. Restricted i.e. flex of flex-ups.

O/E: Obs: - Pt looked quite lethargic. Looked generally unwell.

- ↓ Lx lordosis. Straight back posture.

- ↑ erector spinae activation. (R) > (L).

Lx: AROM

Flex: Hands to knees (P)

Ext: 1/2 range (P)

(P) Side flex 1/4 range (P) little (L)

(L) Side flex 1/2 range (P) (R) Lx

Hips: ✓✓

Knees: ✓✓

Neuro: ✓✓

Palpn: (P) on PAIVMS. Lx Spinal Processes L2 - L5. (P) stool PL

Imp: Mechanical LBP.

Rx: (1) Explanation of findings

(2) Advice + discussion R-E. Pacing activities when feeling "burning" prior to flare-up.

(3) HEP: knee hugs (30 sec holds x 3 throughout day), child's pose (12 x 3 sets throughout day) + seated trunk flex / touch the floor (30 sec holds x 3 sets throughout day).

(4) Explanation for reasoning for particular ex's; Emphasis + of importance of maintaining ex's regu.

P: R/V 1/52. ↑ ex's as able.

Physiotherapist Name Peter Lynch - Student PT Signature Peter Lynch

T

TC

*LIJ
22/9*

Hospital use only

Clinic

SCANNED APPT DETAILS *9/10/20 1pm*

Hospital No.

PHYSIO *Sub: CCHIC*

Date Referral Submitted (This date is fixed at hospital 08-Sep-2020)

LOCATION *ESTER* MEDICAL IN CONFIDENCE

Dup att.

3011795258

CHI No: 3011795258

101021629631U

Unique Care Pathway Number: 101021629631U

REFERRAL TO	
Physiotherapy - Musculoskeletal R5V5 FV Physio - Musculoskeletal	— Consultant / receiving practitioner and/or specialty clinic
Forth Valley Royal Hospital Stirling Road Larbert FK5 4WR	— Hospital and hospital address Hospital location code: <i>cp91a</i> V217H
Routine Physiotherapy - General Musculoskeletal Referral	
Urgency of Referral	
Administrative Information Patient has special requirements: No Ethnic Origin: (White) British	

PATIENT DETAILS	
Surname: Scrimshaw	Patient's address 40 Johnstone Crescent Tillicoultry FK13 6PZ <i>✓ 96 Teacup Dachia FK10 3DP</i>
Forename(s): Gary	
Title: [] Sex: Male	Contact number(s)
Previous Surname: []	
Date of birth: 30-Nov-1979	
CHI no: 3011795258	Voice: 07340830479 E-mail: garyscrimshaw@gmail.com

REFERRING PRACTITIONER DETAILS	
Name: Dr. Andreas Kolle (GMC: 4269506)	Practice address:
Practice: Tillicoultry Medical Practice (25544)	Park Street Tillicoultry FK13 6AG
Phone: Voice: 01259 750531	

DLCA

CLINICAL INFORMATION

History of presenting complaint / examination findings / investigation results

Presenting Complaint

Description: Assessment.

Comment: This 40 year old gentleman works in a factory filling bottles. He has a 4 month history of a painful right shoulder. He points to the regimental badge area on the top of the shoulder, at the back as well. He has limited arc, being able to elevate the arm sideways up to 80 degrees and is unable really to move to a position if he wanted to pour out bottle.

I would be grateful for your further assessment and advice. He asked for some exercises to do and I gave him a link to NHS Inform - musculo skeletal zone to start with. He is already on Co-codamol and Amitriptyline for back problems and I have added some Naproxen today.

Thank you very much.

Kind regards.

Dr A E Kolle
Typed 08.09.2020 - FG

Examinations and Investigations

Murmur present: Not Recorded -
Is a 12 lead ECG: Not done -
Recent CXR: Not done -
FBC: Not Recorded -
Urea and Electrolytes: Not Recorded -
LFT: Not Recorded -
TFT: Not Recorded -
Lipid Profile: Not Recorded -
Glucose: Not Recorded -
Known risks: None

Patient Measurements

Diastolic	Systolic	Height	Weight	BMI	Date Recorded
109	60				17-Aug-2010

Reason for referral

Care type requested: Out Patient
Expected outcome: Investigate

Medical history

Pre-existing Conditions (High Priority)

Description	Laterality	Modifier	Extension	Date Started
[X]Heroin addiction			PRIORITY=1	26-May-2004

Past Procedures (High priority)

Description	Laterality	Extension	Date Recorded
Medication commenced for pain			23-Feb-2010
New medication added			20-Oct-2008

Active Repeat Therapy

Some Repeats may be Active but not Issued. In these instances, the Date Last Issued field contains the date authorised by the GP.

Drug name	Drug code	Formulation	Dosage	Frequency	Last Issued
Naproxen Tablets 500 mg	1001010P0AAAEAE	56 tablet	ONE TO BE TAKEN TWICE A DAY		
Co-Codamol 30/500 Tablets	0407010F0AAAHAH	3*224 TABLET	TWO TO BE TAKEN UP TO A MAXIMUM OF FOUR TIMES A DAY WHEN REQUIRED FOR PAIN		
Amitriptyline Hydrochloride Tablets 25 mg	0403010B0AAAHAH	3*84 TABLET	ONE TABLET ONCE TO THREE TIMES A DAY DEPENDING ON SEVERITY		

Issued Scripts for Acutes and Inactive Repeats (In last 90 days)

No recent medications recorded

Clinical warnings

Smoking status: Number per day: ? (not known)
Description Comment Date Recorded
Cigarette smoker; 20 Cigarettes/day - 26-Jul-2018
Cigarette smoker Smoking status on date of event: Y 06-Apr-2009

Alcohol status: Units per day: ? (not known)

Exercise status: Not Known

Allergies

<u>Description</u>	<u>Comment</u>	<u>Modifier</u>	<u>Start Date</u>	<u>Recorded Date</u>
Adverse reaction to Tramadol-Hydrochloride				

Additional relevant information

<u>Signature of referring doctor (or other professional)</u>	<u>Date</u>
	08-Sep-2020

Routine 5/10/2020 w/p

SCH Minor Injuries Stirling Community Hospital



Date of attendance: 02/10/2020 10:14
Presenting complaint: r shoulder inj

Surname: Scrimshaw		Forename: Gary		Title: Mr	
Address: 40 Johnston Crescent		Postcode: FK13 6PZ		CHI: 3011795258	
Tillicoultry Clackmannanshire		<div style="border: 1px solid black; padding: 5px; text-align: center;"> RECEIVED 05 OCT 2020 </div>			
Telephone: 07340830479					
Date of Birth: 30/11/1979		Sex: Male		Age: 40 Years	
GP Name: AE Kolle					
Address: 25544/1		Telephone: 01259 750531			
Tillicoultry Medical Practice Park Street Tillicoultry Tillicoultry FK13 6AG					
Next of Kin					
Name: Tracey Scrimshaw		Postcode: FK13 6PZ			
Relationship: Wife		Telephone: 07423556817			
Address: 40 Johnston Crescent		Tillicoultry Clackmannanshire			
Triage Information					
Observations					
P=	BP= /	RR=	Sat=	BM=	Temp=
Peak Flow=		GCS=		News=	

Emergency Department / Pre-Hospital Drugs/Allergies					
Date	Drug	Dose	Route	Signature	Given by/Time

MYLO
REF
ACME

Clinical Notes

● Seen by: L YOUNG Time: 1220

PC (K) Shoulder injury

MP: Cycled - fell from bike 3 months ago - jaw GP.

3 days ago - car in front - car keys hit billiard - shoulder hit billiard - L. Ran JICE - MLU.

PM: Shoulder / ACT.

1 movement
1 ml.

It: 10 tingling in fingers.

● MM: ml. At: amphetamine (ordain)

Allergis - nil
(K) handed

~~See 2002
ML
WMM~~

Guidelines Used:

PHILIPPS
SRI NO: 20179268 20/11/99
SAY SCRIMSHAW
10 JOHNSTON CRESCENT
M
TILLCOLTRY
KT13 6PZ

Attach here onto face of pocket
Attach continuation sheets here

Emergency Discharge Letter (Authorised)

AE Kolle
Tillicoultry Medical Practice
Park Street
Tillicoultry
Tillicoultry
FK13 6AG

SCH Minor Injuries
Livlands Gate
Stirling
Stirling
Stirlingshire
FK8 2AU

Dept. Contact Details:

CHI Barcode:



Date of Completion: 02-Oct-2020

GP Practice			
GP Name:	AE Kolle	GP GMC:	4269506
GP Practice Address:	Tillicoultry Medical Practice Park Street Tillicoultry Tillicoultry FK13 6AG	GP Practice Code:	4269506/25544
		GP Clinic Code:	25544/1
		GP Telephone:	01259 750531

Patient Demographics			
Patient Name:	SCRIMSHAW, Gary	Date Of Birth:	30-Nov-1979
Patient Address:	40 Johnston Crescent Tillicoultry Clackmannanshire FK13 6PZ	Gender:	Male
		CHI No:	3011795258
Telephone No:	07340830479		

Admission Details			
Patient Location:	SCH Minor Injuries	Admission Date:	02-Oct-2020
Admission Care Provider:	Dr Joanne Mitchell	Admission Time:	10:14
Source Of Admission:	Not Known		

Presenting Complaint	
r shoulder inj	

Diagnosis		
Diagnosis	Site	Laterality
Calcific Tendinitis of Shoulder		

Procedures	
No Procedure Results	

Medications	
Nil records exist	

Discharge Details			
Discharge Type:	With referral	Discharge Date:	02-Oct-2020
Discharge Destination:	Private Residence - Usual place of residence	Discharge Time:	13:17

Referred To: Physiotherapy

Notes for GP

PC: Right shoulder injury.
 HPC: Fall from bike hitting bollard. Pain in right shoulder since. Already has pain in shoulder since previous fall. No head injury.
 PMH: Nil
 Symptoms: Pain anterior right shoulder. No altered neuro
 OE: No obvious swelling, erythema, bruising, deformity.

Neck NAD

Shoulder- flex 90, Abd 90 LR full. Pain with hand behind back.

MP 5/5 with pain on abd and LR.

Drop arm -ve

NV intact.
 X-RAY: No # seen. RC calcification.
 Treatment: Collar and cuff. 1 - 2 days. Shoulder advice sheet.
 Plan: Physio
 GP Action: Nil

Person completing record

Name:	Specialty:
Designation or role:	Date completed: 02-Oct-2020

Distribution List

Recipient Name	Recipient Type	Recipient Organisation
AE Kelle	GP	Tillicoultry Medical Practice

TELEPHONE CONSULT / NEAR ME CONSULT

09/10/2020

Patient Name: Gory
S. Crimshaw

CHI: 3011795258

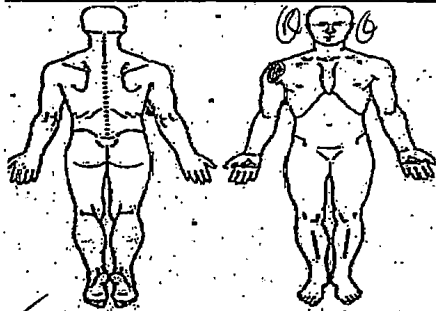
Physiotherapist: Xebia
Anita de BPT

Date and Time: 13:00

PLEASE refer to SCI/CLINICAL PORTAL/ ATTACHED for full details of HPC

PROBLEM AREA: (R) sh. RC calcification

APPROXIMATE LENGTH OF TIME OF CONDITION:



- Felt from road like 30/9/2020 + hit collar
another fall (3/11/2020)

- Pain started after fall, no pain before. Felt like a
dead arm (impingement) until last week

- A Pen since last week
GP - spm him for 2K12 on light duties

emekt

AGG: Abd.
Flex

EASE: Naproxen 500
Hot
Cold

BETTER WORSE SAME (CIRCLE)

24 HOUR PATTERN: Sleep disturbance

NRPS: 0 1 2 3 4 5 6 7 8 9 10 (15)

INVESTIGATES to DATE:

X-ray - Rt / RC calcification

When
moving

INVESTIGATES PENDING:

Nil to note

Gary Scrimshaw 30/11/79

Scheuermann's disease

(2)

PMH: /

GH: T...H...R...E...A...D...S

H/o CA self? Y (N)

Recent weight loss? Y (N)

ANY PERTINENT RED-FLAG QUESTIONS:

SOS - re

OBSERVATIONS:

& RoA: ✓ GH flex: 80
abd 40
HBS k

elbow/wrist/hand ✓

△ frame? calcification?

TREATMENT/DISCUSSION

HEP (anal &) see cc sheet
bad management, aggression, POLICE + PEACE AND LOVE

PLAN

EZF in 452
pt happy & plan

dobier Anztopia BGPT
09/10/2020

MEDS: - Amphotericin (since Apr 17) x2-3 (25mg tablet)

- naproxen

- Co-codamol 30/500 x8 (hans) this is for

SH: Scheuermann's

- Works in brewery (physical +)

- Kyle

- Abs x2 children (5,13)



Personal exercise program

Physiotherapy exercises

NHS Forth Valley
NHS Forth Valley
Unit 2 Colquhoun Street, FK10 3BJ, Stirling, United Kingdom

Provided by Xabier Ariztegieta
Provided for Gary Scrimshaw.

8-20 x 2-3

As able



©Physiotoools

Sit. Hold a stick upright in front of you as far away as possible from your body with the end of the stick resting on the floor.

Lean forwards.

Repeat _____ times.



©Physiotoools

Lying on your back with elbows straight.

Use one arm to lift the other arm up keeping it as close to the ear as possible.

Repeat _____ times.



©Physiotoools

Stand with your upper arm close to your side, elbow at a right angle and the back of your hand against a wall.

Push the back of your hand against the wall. Hold approx. _____ secs.

Repeat _____ times.



©Physiotoools

Stand or sit. Hold your upper arm close to your body with your elbow at a right angle.

Try to move your hand outward, resisting the movement with the other hand. There should be no movement.

Hold _____ seconds.

Repeat _____ times.

Gary Scribshaw 30/11/79

16/10/11

t/c in air -ve COVID19 as -ve. However pt R. Scheibild
apt afterwards (through the hrs) as he is not comfortable
coming to the department

pt reported feeling 100% better in air t/c

① t/c in 1/52. DIC? X Anzberger 36A

20/10/2020

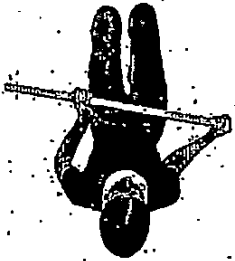
PTA. mesle to left vm on mobile nurse

① on hold for 2/52. X Anzberger

3/11/2020

no further contact with DIC

X Anzberger



©Physiotools

Lying on your back with elbows against your body and at a right angle. Hold a stick in your hands.

Move the stick sideways thus pushing the arm to be exercised outwards.

Repeat _____ times.



©Physiotools

Lie on your back. Hold a _____ kg weight.

Lift your arm keeping your elbow straight.

Repeat _____ times.



©Physiotools

Stand with feet apart. Hold a stick or weight with both hands close together.

Lift the stick/weight to your chin. Your elbows should point outwards and upwards while doing the exercise.

Repeat _____ times.



©Physiotools

Sit or stand with hands clasped in front of you.

Lift your hands above your head and stretch your arms as far back as possible.

Repeat _____ times.



Personal exercise program

Physiotherapy exercises

NHS Forth Valley
NHS Forth Valley
Unit 2 Colquhoun Street, FK10 3BJ, Stirling, United Kingdom

Provided by Xabier Ariztegieta
Provided for Gary Scrimshaw



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Repeat _____ times.



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Lying on your back with elbows straight.

Use one arm to lift the other arm up keeping it as close to the ear as possible.

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©Physiotools

Stand with your upper arm close to your side, elbow at a right angle and the back of your hand against a wall.

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Repeat _____ times.



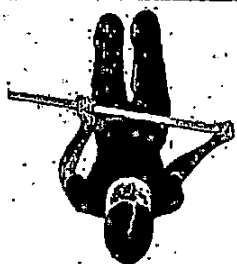
©Physiotools

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Hold _____ seconds.

Repeat _____ times.



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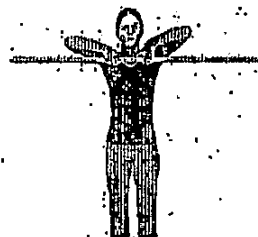


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Repeat _____ times.



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Repeat _____ times.



©Physiotools

Sit or stand with hands clasped in front of you.

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Repeat _____ times.

Immediate Discharge Letter (Authorised)

COPY

G Campbell
Tillicoultry Medical Practice
Park Street
Tillicoultry
Tillicoultry
FK13 6AG

Acute Medicine
Stirling Road
Larbert
Larbert
Stirlingshire
FK5 4WR

Dept. Contact Details:

CHI Barcode:



Date of Completion: 21-May-2024

Patient Demographics			
Patient Name:	SCRIMSHAW, Gary	Date Of Birth:	30-Nov-1979
Patient Address:	40 Johnston Crescent Tillicoultry Clackmannanshire FK13 6PZ	Gender:	Male
		CHI No:	3011795258
Telephone No:	07340830479		

GP Practice			
GP Name:	G Campbell	GP GMC:	7277373
GP Practice Address:		GP Practice Code:	7277373/25544
		GP Clinic Code:	25544
		GP Telephone:	

Admission Details			
Patient Location:	Acute Medicine	Admission Care Provider:	Dr Daniel Beckett
Admission Date:	21-May-2024	Admission Time:	15:11
Admission Method:	Emergency Admission, no additional detail added	Ward:	FVRH UCC SDEC
Source Of Admission:	GP Non Obstetrics - other Provider		

Discharge Details			
Discharge Specialty:	Acute Medicine	Discharge Care Provider:	Dr Daniel Beckett
Discharge Date:	21-May-2024	Ward:	FVRH UCC SDEC
Discharge Time:	16:49	Discharge Destination:	Private Residence - no additional detail added
Discharge Method:	Regular discharge, no additional detail added		

Clinical Summary including History	
Dear Dr,	
Gary attended RACU with 1/52 history of chest tightness and SOB intermittent in nature. Non exertional. Describes episode yesterday severe with associated clamminess with palpitations whilst at work. No cough/ feverish symptoms/ nausea.	
Obs/ BP 131/82 hr 54 rr16 O2 98% ra. temp 36.3C OE/ pulse reg HS I+II+O chest clear ECG nsr CXR nad Bloods checked in ED 20/5 no change in presentation normal FBC, UES, LFTs, troponin. D dimer checked today normal.	

Immediate Discharge Letter (Authorised)

COPY

G Campbell
Tillicoultry Medical Practice
Park Street
Tillicoultry
Tillicoultry
FK13 6AG

Acute Medicine
Stirling Road
Larbert
Larbert
Stirlingshire
FK5 4WR

Dept. Contact Details:

CHI Barcode:



Date of Completion: 21-May-2024

Patient Demographics			
Patient Name:	SCRIMSHAW, Gary	Date Of Birth:	30-Nov-1979
Patient Address:	40 Johnston Crescent Tillicoultry Clackmannanshire FK13 6PZ	Gender:	Male
Telephone No:	07340830479	CHI No:	3011795258

GP Practice			
GP Name:	G Campbell	GP GMC:	7277373
GP Practice Address:		GP Practice Code:	7277373/25544
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Admission Method:	Emergency Admission, no additional detail added	Ward:	FVRH UCC SDEC
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Obs/ BP 131/82.hr 54 rr16 O2 98% ra. temp 36.3C	
OE/ pulse reg HS I+II+O chest clear	
ECG nsr	
CXR nad	
Bloods checked in ED 20/5 no change in presentation normal FBC, UES, LFTs, troponin. D dimer checked today normal.	

Imp/ MSK injury / stress

Plan/
Home with worsening statement

Should you require any further information please contact RACU.

Kind regards, Dr Catriona Parker GPWSI acute medicine



Safety Alerts

Nil records exist

Allergy/Intolerance

Allergy records are as recorded at time and date of printing

Nil records exist

Medications

Drug Information:

Drug	Dose	Route	Frequency	GP to Continue	POD	Days Supply
------	------	-------	-----------	----------------	-----	-------------

Nil records exist

Drug Notes:

Drug	Drug Notes
------	------------

Nil records exist

Additional Medicine Information:

Medicines discontinued during admission (Medicines that patient was recorded as admitted on only)

Drug	Discontinued Reason
------	---------------------

Nil records exist

GP Communications:

Outstanding Results

Responsibility of Hospital

Nil records exist

Person completing record

Authorised by

Name:
Designation or role:
Specialty:
Date completed: 21-May-2024

Clinically completed by

Name:
Designation or role:
Specialty:

Distribution List

Recipient Name	Recipient Type	Recipient Organisation
G Campbell	GP	Tillicoultry Medical Practice

Imp/ MSK injury / stress

Plan/
Home with worsening statement**COPY**

Should you require any further information please contact RACU.

Kind regards, Dr Catriona Parker GPWSI acute medicine

Safety Alerts

Nil records exist

Allergy/Intolerance

Allergy records are as recorded at time and date of printing

Nil records exist

Medications**Drug Information:**

Drug	Dose	Route	Frequency	GP to Continue	POD	Days Supply
------	------	-------	-----------	----------------	-----	-------------

Nil records exist

Drug Notes:

Drug	Drug Notes
------	------------

Nil records exist

Additional Medicine Information:

Medicines discontinued during admission (Medicines that patient was recorded as admitted on only)

Drug	Discontinued Reason
------	---------------------

Nil records exist

GP Communications:**Outstanding Results****Responsibility of Hospital**

Nil records exist

Person completing record**Authorised by**

Name:

Designation or role:

Specialty:

Date completed:

21-May-2024

Clinically completed by

Name:

Designation or role:

Specialty:

Distribution List

Recipient Name	Recipient Type	Recipient Organisation
G Campbell	GP	Tillicoultry Medical Practice

Date of arrival: 21/05/24 Time of arrival: 15:00

CHI: 3011795258 30/11/1979 M

44

Source of referral: GP ED Other SAS

Name: SCRIMSHAW, Gary
40 Johnston Crescent
Tillicoultry
Clackmannanshire
FK13 6PZ

COPY

GP Practice: Tillicoultry

Address:

Telephone Number: 07340830479

NOK Name: Tracey

Address:

Telephone Number: 074235 56 817

Relationship: Wife

ALLERGIES:

NOKA

Reason for assessment:

chest pain

Medications:

Co-codamol 30/500 x2
naproxen 500mg qd
omeprazole 10mg
capasal
AMT 20mg ON

Name: Victory Adebayo

Signature: *Victory Adebayo*

Date: 21/05/24

Time: 15:05

(addressograph)

3011795258 30/11/1979 M
SCRIMSHAW, Gary
40 Johnston Crescent
Tillicoultry
Clackmannanshire
FK13 6PZ

COPY

Assessment

Presenting Complaint:

CP + SOB

HPC:

1/52 history of intermittent chest tightness
and SOB non exertional severe episode last
night.
no cough/fevers
attended ED.
feels worse
EKG + bloods
no nausea
didn't wait for
E+D dx
results
no weight loss
assoc clamminess
+ palpitations

Systemic Enquiry:

~~no~~ PU overnight more

PMH:

nil

Social History:

Smoking/Vape: 20/day
No/Yes pack years

Alcohol: Units/week nil

Live with: wife

Support/carers:

Occupation:

works in a Brewery

Family History:

dad - stroke

(addressograph)

3011795258 30/11/1979 M
SCRIMSHAW, Gary
40 Johnston Crescent
Tillicoultry
Clackmannanshire
FK13 6PZ

COPY

Impression:

? MSK
exclude PE

Plan:

Moods in ED yesterday brop ES
NDUS, FRK
no worsening presentation therefore
cardiac ~~is~~ cause unlikely.
EKG → read
check D. Brewer ⊖
HJ ~ MSK

Name:	Sign:	Date:	Time:
		21/5/20	1545

Patient Information

GARY SCRIMSHAW

Age/Gender: 44y Old

Address: 40 JOHNSTON CRESCENT TILlicouLTRY, FK13 6PZ

DOB: 30/11/1979

CHI: 3011795258

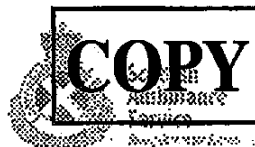
Ethnicity:

Date: 21/05/2024

Incident Number: CR010942614

Incident Type: EMG

Incident Location: 40 JOHNSTON CRESCENT TILlicouLTRY, FK13 6PZ



Presenting Complaint

CHEST PAIN

Additional Comments

Nhs 24 call for a 44yom o/a pt was sitting outside with family, pt gcs 15, alert, orientated, good colour and talking in full sentences. Pt has had ongoing chest pain for the past week, pt work called for an ambulance yesterday as pt felt he was going to pass out and had chest pain radiating down his arms, pt was taken to fvrh where he self discharged due to needing to be home for child care, pt had bloods and ecg but did not receive any results. Pt called nhs 24 this morning due to ongoing chest tightness and the feeling his heart is bruised. Pt is under alot of stress at work but normally is not effected by stress o/e all obs are as charted below, pt ecg NSR, chest clear in all fields, pt has not been doing any unusual heavy lifting from his normal amount, pt has not had and blunt force trauma to his chest, pt does not have a cough or bringing up phlegm, socrates filled out, crew called low risk chest pain who accepted pt at racu. Not aware of any family history of cardiac problems, Pt transported to racu for further assessment. nok-wife- tracey- 07423556817

PATIENT ASSESSMENT

ACVPU Alert

<C> No

A Clear

B Breathing Adequately Yes

Respiratory Rate 16

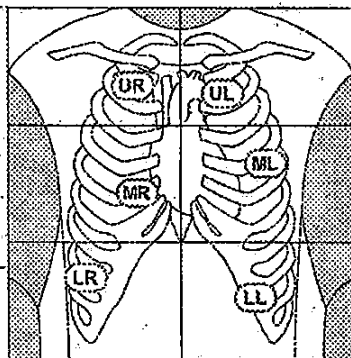
SPO2

98

Oxygen Given No

Normal Breath Sounds, Normal Air Entry

UR



Normal Breath Sounds, Normal Air Entry

UL

Normal Breath Sounds, Normal Air Entry

MR

Normal Breath Sounds, Normal Air Entry

ML

Normal Breath Sounds, Normal Air Entry

LR

Normal Breath Sounds, Normal Air Entry

LL

C Pulse Rate

74

139/79

BP

Cap Refill

<=2 Secs

ECG Rhythm

Sinus Rhythm

Rhythm

Arm

Central/Peripheral

ECG

Reg

Right

Peripheral

12 Lead

D

GCS

15

Eyes

Spontaneously (4)

Voice

Orientated (5)

Motor

Obeys Commands (6)

PEARL

N/A

Observations

Time	P	RR	BP	SpO2	CR	GCS	ACVPU	ETCO2	T	BM	ECG	P(L)	P(R)	PEF	CrewID
14:20	68	16	130/75	97	<=2s	15	Alert		36.8	6.9	Sinus Rhythm				E9886022
13:57	74	16	139/79	98	<=2 Secs	15	Alert		36.8	6.9	Sinus Rhythm				E9886022

NEWS2

Time	RR	SpO2 Scale 1	SpO2 Scale 2	Air/O2	BP	P	ACVPU	T	Total
14:20	16 (0)	97 (0)		0	130 (0)	68 (0)	Alert (0)	36.8 (0)	0

Last: Scrimshaw
First: Gary
ID: 301179525B
DOB: 30-Nov-1979
Age: 44yr
Comment:
Tech:
Ref Phys:

Sex: Male

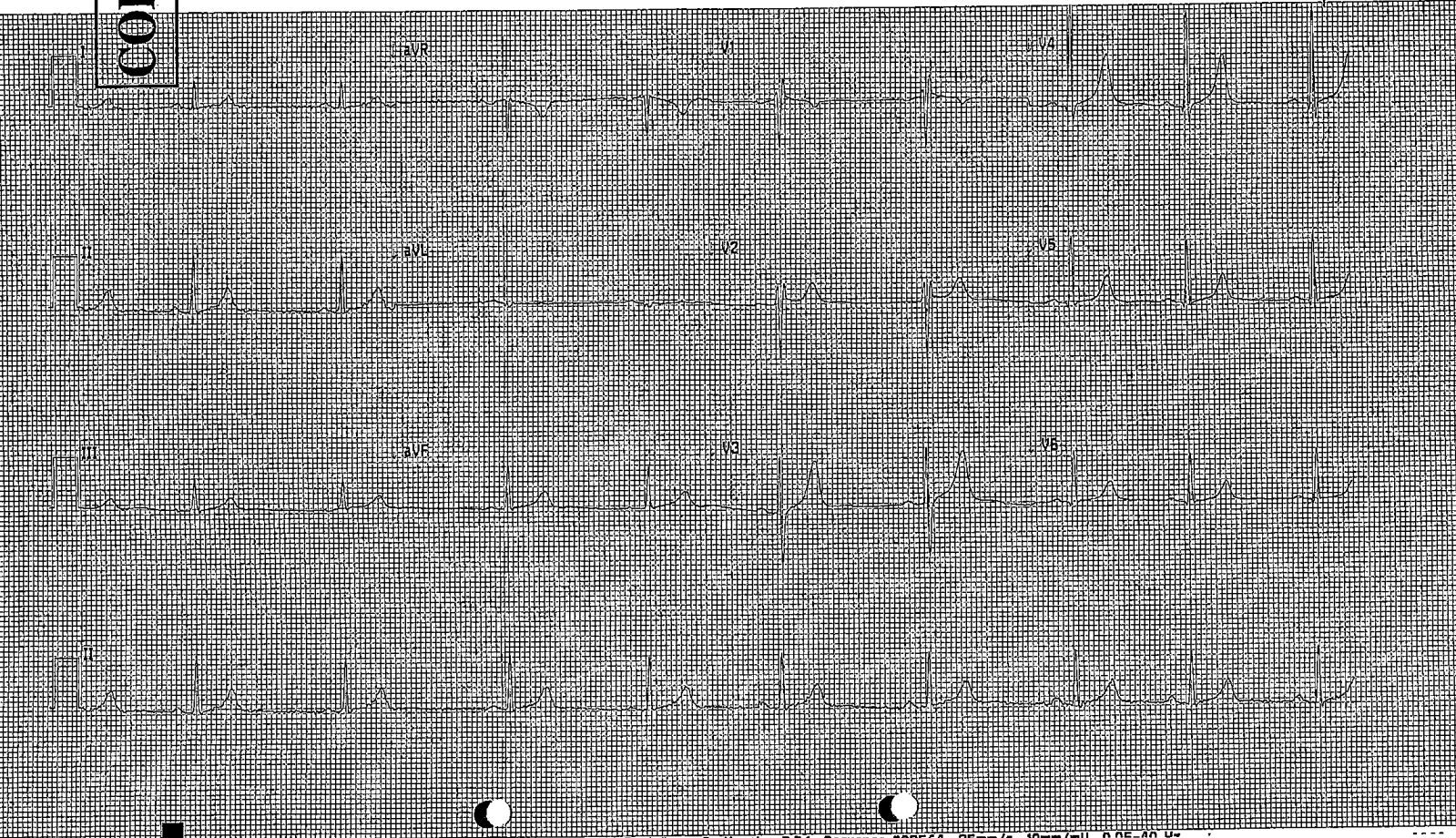
21-May-2024 15:17:42
Vent rate: 54 BPM
PR int: 160 ms
QRS dur: 98 ms
QT/QTc: 408/394 ms
P-R-T axes: 44 66 64

SINUS BRADYCARDIA WITH SINUS ARRHYTHMIA
POSSIBLE RIGHT VENTRICULAR CONDUCTION DELAY (RSR (QR) IN V1/V2)
BORDERLINE ECG

UNCONFIRMED REPORT

?LVH unchanged w/ly
?RVB/B from previous @ Scrimshaw

COPY



30 MINIS 30 MINIS 30 MINIS

MISS ON: 20240521 12:55:10 Time: 14:02
MISS ON: Start: 21:05:2024 UTC+01:00

Patient: GARY SCHUMSKY
ID: (Age) 30/117 (LMA)
Case No.:

NIBP: 139/79/(99)7 mmHg
PR: /min
RR: 36 /min



Device: 0002447
Radio:
Medical team:
Call back phone: 0792071633
ECG filter: 0.05 / 40 Hz
Main filter: 50 Hz

Page 1 REL-3:13:03:BP

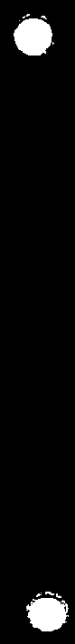
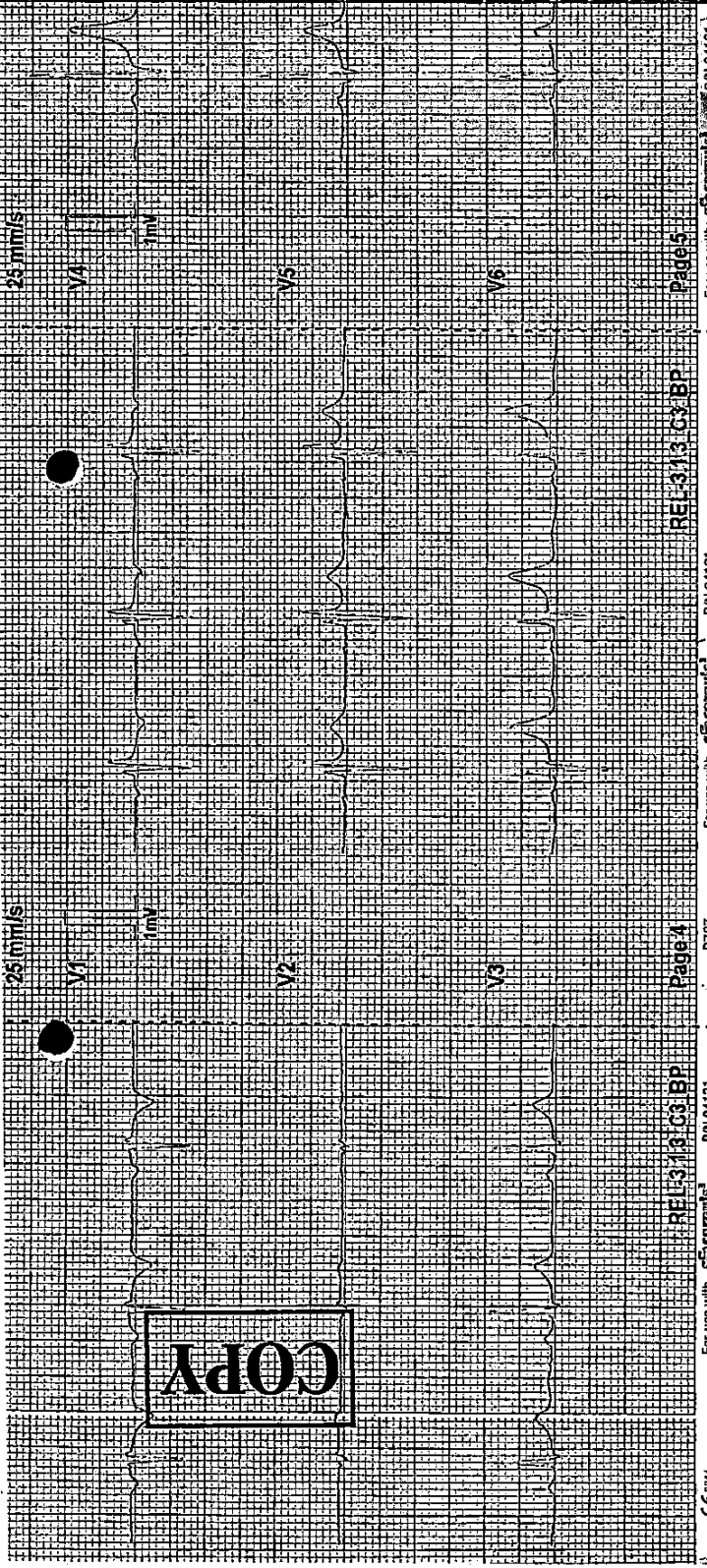
Page 2

Page 3

Page 4 REL-3:13:03:BP

For use with For use with For use with For use with P/N 04121

COPY



50 mm/s

0.5 mV

COPY

aVR

V1

V4

aVL

V2

V5

aVF

V3

V6

25 mm/s

1 mV

REL-3-13-C3-BP

Page 6

For use with P/N 04121

C 0042

For use with P/N 04121

P/N 04121

D787

For use with P/N 04121

P/N 04121

For use with P/N 04121

P/N 04121

NEWS key

1	2	3
---	---	---

FULL NAME: Gary Scrimshaw
 DATE OF BIRTH: 30/11/1979

DATE 21/5/21/5
 TIME 15:00 15:05

COPY

Respirations Breaths/min	≥25		
	21-24		
	18-20		
	15-17	16	16
	12-14		
	9-11		

SpO ₂ Scale 1 Oxygen saturation (%)	≥96	97	98
	94-95		
	92-93		
	≤91		

SpO ₂ Scale 2 Oxygen saturation (%)	≥97 on O ₂		
	95-96 on O ₂		
	93-94 on O ₂		
	≥93 on air		
	88-92		
	86-87		
	84-85		

Air or oxygen?	A=Air	0	0
	O ₂ L/min		
Device			

Pulse Beats/min	≥220		
	201-219		
	181-200	2	2
	161-180		
	141-160		
	121-140	120	131
	111-120		
	101-110		
	91-100		
	81-90		
	71-80		
	61-70		
	≤50		

Consciousness Score for NEWS onset of confusion (no score if chronic)	Alert	✓	✓
	Confusion		
	V		
	P		
	U		
	≥39.1°		
	38.1-39.0°		
	37.1-38.0°		
	36.1-37.0°	36.3	36.3
	35.1-36.0°		

NEWS TOTAL	0	10
	Monitoring frequency	4hr 4hr
	Escalation of care Y/N	N N
	Blood Sugar	/ /
	Pain Score 0-3	1 1

Initials: G. V. T. O. N. A.

SCRIMSHAW, Gary
 -40 Johniston Crescent
 Tillicoultry
 Clackmannanshire
 FK13 6PZ
 NEW
 8237397

National Early Warning Score (NEWS2)



Name: 3011795258 30/11/1979 M
 SCRIMSHAW, Gary
 40 Johnston Crescent
 Tillicoultry
 Clackmannanshire
 FK13 6PZ

DOB:

CHI No:

Address:

COPY

*** Regardless of NEWS always escalate if concerned about a patient's condition**

Total NEWS	Frequency of Monitoring	Clinical Response
0*	Minimum 12 hourly	<ul style="list-style-type: none"> Continue routine NEWS monitoring with every set of observations
1 - 4 *	Minimum 4 - 6 hourly	<ul style="list-style-type: none"> Inform registered nurse who must assess the patient Registered Nurse to decide if increased frequency of monitoring and / or escalation of clinical care is required
5 - 6 * or 3 in one Parameter	Increased frequency to a minimum of 1 hourly	<ul style="list-style-type: none"> Registered nurse to urgently inform the medical team caring for the patient Urgent assessment by a clinician with core competencies to assess acutely ill patients Ensure structured Response Stickers A & B are completed (<i>Not Applicable in Emergency Dept</i>)
7* or more	Continuous monitoring of vital signs (3 lead ECG and continuous SpO2 monitoring, 15 minute BP cycling - document observations every 30 minutes)	<ul style="list-style-type: none"> Registered nurse to immediately inform the medical team caring for the patient Emergency assessment by clinical team with core competencies to assess acutely unwell patients Ensure structured Response Stickers A & B are completed (<i>Not Applicable in Emergency Dept</i>) Consider transfer of clinical care to ITU

Exclusion Criteria

Anaesthesia and/or sedation may result in reduced conscious levels for a period of time. Scores that are increasing post-procedure and those including "P" or "U" always require escalation. The post-procedure NEWS score and post procedure plan that will include the frequency of observations should be communicated to the ward staff on transfer/handover of the patient.

Target O2 Saturation

Target SpO2 for most patients should be 94-98%.

Selected patients may require target SpO2 88-92% (Appropriate in specific patients with severe chronic respiratory disease who either have established chronic Type 2 respiratory failure, or are felt to be at significantly increased risk of CO2 retention from oxygen therapy). These patients should use the modified (chronic hypercapnia) EWS. Arterial blood gases should be repeated at 30-60 min to check for rising CO2 or H+ after initiation of oxygen in this context.

Acute Respiratory Failure is a life threatening emergency

Severe Hypoxia (Requiring >60% O2 to maintain target SpO2)

Acute Hypercapnia (pCO2 >6 and H+ >45)

Urgent ST3 (or equivalent) review is required to optimise management.

Duty or on call consultant should be contacted if advice required.

Critical care referral and ventilatory support may be needed.

Codes For Recording Oxygen Delivery On NEWS Chart

A = Air (not requiring oxygen or weaning or on PRN oxygen)

N = Nasal Canulae

SM = Simple Mask

V24 = Venturi 24% V28 = Venturi 28% V35 = Venturi 35% V40 = Venturi 40% V60 = Venturi 60%

H28 = Humidified oxygen at 28% (also H35, H40 & H60 = Humidified Oxygen at 35%, 40% & 60%)

RM = Reservoir Mask

TM = Tracheostomy Mask

CP = Patient on CPAP System

NIV = Patient on NIV System

OTH = Other Device: _____ (specify which)

Pain Score

0 = no pain

1 = mild pain

2 = moderate pain

3 = severe pain

Supportive and Palliative Care Indicators Tool (SPICT™)

COPY

Review Date: 2025

The SPICT™ is a guide to identifying people at risk of deteriorating and dying. Assessment of unmet supportive and palliative care needs may be appropriate.

Look for two or more general indicators of deteriorating health.

- Performance status poor or deteriorating, with limited reversibility. (needs help with personal care, in bed or chair for 50% or more of the day).
- Two or more unplanned hospital admissions in the past 6 months.
- Weight loss (5 - 10%) over the past 3 - 6 months and/or body mass index < 20.
- Persistent, troublesome symptoms despite optimal treatment of any underlying condition(s).
- Lives in a nursing care home or NHS continuing care unit, or needs care to remain at home.
- Patient requests supportive and palliative care, or treatment withdrawal.

Look for any clinical indicators of advanced conditions

Cancer

Functional ability deteriorating due to progressive metastatic cancer.

Too frail for oncology treatment or treatment is for symptom control.

Dementia / frailty

Unable to dress, walk or eat without help.

Choosing to eat and drink less; difficulty maintaining nutrition.

Urinary and faecal incontinence.

No longer able to communicate using verbal language; little social interaction.

Fractured femur; multiple falls.

Recurrent febrile episodes or infections; aspiration pneumonia.

Neurological disease

Progressive deterioration in physical and/or cognitive function despite optimal therapy.

Speech problems with increasing difficulty communicating and/or progressive dysphagia.

Recurrent aspiration pneumonia; breathless or respiratory failure.

Heart / vascular disease

NYHA Class III/IV heart failure, or extensive, untreatable coronary artery disease with:

- breathlessness or chest pain at rest or on minimal exertion.

Severe, inoperable peripheral vascular disease.

Respiratory disease

Severe chronic lung disease with:

- breathlessness at rest or on minimal exertion between exacerbations.

Needs long term oxygen therapy.

Has needed ventilation for respiratory failure or ventilation is contraindicated

Kidney disease

Stage 4 or 5 chronic kidney disease (eGFR < 30ml/min) with deteriorating health.

Kidney failure complicating other life limiting conditions or treatments.

Stopping dialysis.

Liver disease

Advanced cirrhosis with one or more complications in past year:

- diuretic resistant ascites
- hepatic encephalopathy
- hepatorenal syndrome
- bacterial peritonitis
- recurrent variceal bleeds

Liver transplant is contraindicated.

Assess and plan supportive & palliative care

- Review current treatment and medication so the patient receives optimal care.
- Consider referral for specialist assessment if symptoms or needs are complex and difficult to manage.
- Agree current and future care goals/plan with the patient and family.
- Plan ahead if the patient is at risk of loss of capacity.
- Handover: care plan, agreed levels of intervention, CPR status.
- Coordinate care (eg. with a primary care register).

Re-order Ref: TF/1013/SS

NEWS2

Ophthalmology Department
Consultant: J. Angus Scott
Tel: 01786 434000 Ext.4637
Fax:

Stirling Royal Infirmary
Livilands
Stirling
FK8 2AU

COPY

Ref: RI/RR/S237397
CHI: 3011795258

Clinic Date: 30 August 2010
Date: 07 September 2010

Dr Andreas Kollé
Tillicoultry Medical Practice
Park Street
Tillicoultry
FK13 6AG

Dear Dr Kollé

GARY SCRIMSHAW 30/11/1979
22/4 HILL STREET TILLICOLTRY CLACKMANANSHIRE FK13 6HF

I reviewed this gentleman today who had an acute right painful eye last week. His conjunctival swabs came to be negative today.

On examination today his right visual acuity was 6/12 improved to 6/9 with pinhole. Left visual acuity was 6/6. He has a right small healing corneal abrasion with otherwise unremarkable inferior and posterior segments. In addition there is no relative afferent pupillary defect and colour vision was full in both eyes. I have advised him to continue using the Exocin eye drops for a further four days. I have discharged him from the clinic.

Yours sincerely

Dr Rehab Ismail
ST2 in Ophthalmology to
J Angus Scott
Consultant Ophthalmologist

PLEASE USE BLOCK CAPITALS EXCEPT FOR SIGNATURE

Referral/Notification of Patient to GMP

SECTION ONE: To Be Sent To GMP To: Dr. PCC 30/08/10 **COPY**

PATIENT'S DETAILS

SURNAME (Mr, Mrs, Miss, Ms) SCHEMSTAN OTHER NAME(S) GARY

ADDRESS FLAT 4, 22 HILL STREET, TILLCOUNTRY

POSTCODE FK13 6HF TEL. No.

PRESCRIPTION DETAILS FROM CURRENT SIGHT TEST-DATE:										Previous corrected V.A.	Date of Birth
	Uncorrected V	Sph	Cyl	Axis	Prism	Base	VA	Add	Near VA	Date	
R											Specify Cycloplegic/Mydriatic if used.
L											

POINTS REQUIRING ATTENTION - FOR INFORMATION (AND POSSIBLE REFERRAL):

This gentleman attended today with a very sore left eye. He says this started yesterday and his vision has dropped to about 20% today. He is also very photophobic. IOLs are R 22 L 25 mmHg @ 9:30 am today. I instilled fluorescein but was unable to shine any light in his eye to determine the problem.

Optic discs

IOP R mmHg Tonometer used:
L mmHg Applanation/Tonometer

Visual Fields
R L

Plot attached ... Y/N

Name and Address of Optometrist/OMP
MARY ROBERTSON
COXLEYEYES
105 HILL ST
TILLCOUNTRY

Signed (Optometrist/OMP) Date 25.8.10

I agree / do not agree that any Ophthalmologist to whom I am referred for medical consultation and / or treatment may make information relevant to my eye condition and its treatment available to my Optometrist / Ophthalmic Medical Practitioner.

Signature Date

SECTION TWO: To Be Completed By General Medical Practitioner (if not accompanied by formal referral letter)

To: Dr. / Mr. / Mrs. / Miss / Ms _____

RELEVANT CLINICAL HISTORY - INCLUDE MEDICAL/FAMILY/OPHTHALMIC AND DETAILS OF MEDICATION:

Urgency Rating: Urgent/Soon/In turn

Blood Pressure: mmHg

Urinalysis:

Provisional Diagnosis:

Name and Address of GMP

Signed (GMP) Date

Part One - This part must accompany any referral and be retained by the Ophthalmologist

STIRLING ROYAL INFIRMARY
LIVILANDS
STIRLING
FK8 2AU

GASTROENTEROLOGY UNIT - Fax: 01786 434461



Forth Valley

Consultant: Dr. Stuart Paterson
Consultant Physician - Gastroenterologist

Dr Peter Bramley
Dr Hugh Dalziel
Dr David Watts
Dr David Oliver
Dr Stuart Paterson
Associate Specialist: Dr Patrick Law

Secretary: Julie McCormack - Tel: 01786 433661

Patient Details:

G.P. Details

DR BOLLAND

Date: 26/08/10

MR GARRY SCRIMSHAW

7 MOSS ROAD,
TILLCOUNTRY,
GLACKMANNANSHIRE

FK13 6NS

Health Centre 3

Hall Park ROAD

Sauchie

FK10 3JQ

Dear Doctor

Following this patient's recent hospital admission, the case notes have been reviewed together with the Immediate Discharge Summary. We consider the discharge summary to be accurate and please accept it as a complete and final summary of this patient's recent admission.

Any outstanding issues are listed below:

Discharge Date: 22/8/10

Follow Up Required:

No

Yes

Arranged / To Be Arranged

Results Outstanding:

Nil

*As per psychiatry
please copy d/c to
Dr Collins - Consultant
psychiatrist
Stirling Royal*

Signed:

CVO

Page No:

096



INVESTOR IN PEOPLE

Chairman Ian Mullen OBE BSc MRPharmS DL
Chief Executive Fiona Mackenzie MA(Hons) MBA CIHM DipISM

Forth Valley NHS Board is the common name for Forth Valley Health Board
Registered Office: Carseview House, Castle Business Park, Stirling, FK9 4SW

www.nhsforthvalley.com

Immediate Discharge Letter

NHS

Forth valley
COPY

Hospital: Stirling Royal Infirmary

Tel (SRI): 01786 434 000

Fax (SRI): 01786 430 488

Tel (FVRH): 01324 566 000

Tel (FDRI): 01324 624 000

Fax (FDRI): 01324 617 421

Consultant: Paterson, Dr Stuart

Specialty: General Medicine

Discharging Ward:

SRI - Ward 1

GP Details	Patient Details	Admission Details
Practice Code: 25031	Patient CHI No: 3011795258	Admission Date: 20/08/2010
GP Name: Dr David S Borland	Patient Hospital No: S237397	Admission Type: Emergency - Injury - Self Inflicted (Injury or Poisoning)
Address: Health Centre Practice 3, Hallpark Road, Sauchie, K10 3JQ	Surname: Scrimshaw	Presenting Complaint: Overdose and Poisoning
	Forename: Garry	
	Date of Birth: 30/11/1979	Discharge Date: 22/08/2010
	Address: 7 Moss Road,, Tillicoultry,, Clackmannanshire, FK13 6NS	Discharge To: Private Residence - Living Alone

Diagnosis/Problem List

Xa6Dd - Intentional amitriptyline overdose

Additional comment (Progress, Investigations, Procedures, Complications etc)

Admitted to ITU after being found face down on floor unconscious. Empty blister packs in the immediate area suggested mixed overdose. Intubated in ITU overnight due to reduced conscious level. Central line and arterial line inserted for supportive treatment and monitoring.

Paracetamol level - 236

Salicylate - undetected

Routine bloods - U&E, LFT, FBC all normal. Coag normal

Treated with IV parvolex. Extubated the morning after admission and transferred to the ward later that day. Seen by psychiatric SHO on call - no ongoing suicidal ideation. They will arrange urgent follow up with Dr Collins.

Plan: allow home. No medications.


Procedure	Performed	Time
Mechanical ventilation	20/08/2010	

Results Outstanding (Y/N) If yes, give details:	No
--	----

Information to patient/carer (Y/N):	Patient: Yes Carer (if applicable): No
-------------------------------------	---

Follow up arrangements

There are no Reviews planned

Authorisor's name: L Fabisiak	Doctor's Signature:  COPY
Authorisor's grade: Advanced Nurse Practitioner	
Lead/Approved by:	
Date: 22/08/2010	
Discharge Ward Nurse: Murphy, John	

Validation/Contact Name: Paterson, Dr Stuart

Name: Mr Garry Scrimshaw

THIS IS THE FINAL DOCUMENT
CHI: 3011795258

Forth Valley Acute Hospitals Acute Division
Medications Discharge Summary

Name:	Mr Garry Scrimshaw	Patient's Tel No:	COPY
Address:	7 Moss Road,, Tillicoultry,, Clackmannanshire, FK13 6NS	Patient's Tel Eve:	
Admission Date:	20/08/2010	Discharge Date:	22/08/2010

PATIENT ALERTS

Alert Group	Alert	Alert Comment	When Added	Added By
-------------	-------	---------------	------------	----------

PATIENT DRUG REACTIONS

CURRENT PRESCRIPTION (all medicines currently prescribed) **e.g. clinical indication for prescription monitoring*

MEDICINES DISCONTINUED

Nurse check on discharge:

Signature 1:

Signature 2:

Name: Mr Garry Scrimshaw

CHI: 3011795258

As Required Medication Page

(Prescribers **MUST** enter indication, dosage interval and maximum daily dose)

COPY

- enter dosage times as 24hour clock
- please write in block capitals in black pen

- Maximum of 3 continuation sheets (or 5 for long stay patients with Consultants approval).
- please ensure patient details on each sheet

			DATE →						
APPROVED DRUG NAME			DOSE	ROUTE	TIME				
Sodium Chloride 0.9%				IV	GIVEN BY				
INSTRUCTIONS			PHARMACY		TIME				
for flush			Clin		GIVEN BY				
			POD	Y N	TIME				
			D/C	Y N	GIVEN BY				
SIGNATURE	DATE	DISP ₁			TIME				
		DISP ₂			GIVEN BY				
APPROVED DRUG NAME			DOSE	ROUTE	TIME	02-10			
DIHYDROCODEINE			30mg	PO	GIVEN BY	IB			
INSTRUCTIONS			PHARMACY		TIME				
Every 4 to 6 hours			Clin		GIVEN BY				
			POD	Y N	TIME				
			D/C	Y N	GIVEN BY				
SIGNATURE	DATE	DISP ₁			TIME				
		DISP ₂			GIVEN BY				
APPROVED DRUG NAME			DOSE	ROUTE	TIME				
INSTRUCTIONS			PHARMACY		GIVEN BY				
			Clin		TIME				
			POD	Y N	GIVEN BY				
			D/C	Y N	TIME				
SIGNATURE	DATE	DISP ₁			GIVEN BY				
		DISP ₂			TIME				
APPROVED DRUG NAME			DOSE	ROUTE	TIME				
INSTRUCTIONS			PHARMACY		GIVEN BY				
			Clin		TIME				
			POD	Y N	GIVEN BY				
			D/C	Y N	TIME				
SIGNATURE	DATE	DISP ₁			GIVEN BY				
		DISP ₂			TIME				
APPROVED DRUG NAME			DOSE	ROUTE	TIME				
INSTRUCTIONS			PHARMACY		GIVEN BY				
			Clin		TIME				
			POD	Y N	GIVEN BY				
			D/C	Y N	TIME				
SIGNATURE	DATE	DISP ₁			GIVEN BY				
		DISP ₂			TIME				

General Medication Page

(General Medication starts at front and works forward. Intravenous Medication starts at back and works forward)

- enter dosage times as 24hour clock
- please write in block capitals
- please write in black pen

- Maximum of 3 continuation sheets (only for long term patients with Consultants approval).
- please ensure patient details on each sheet

COPY

		DATE →															
		TIME ↓															
APPROVED DRUG NAME <i>G. Exocin</i>		DOSE		ROUTE <i>1</i>													
INSTRUCTIONS <i>Daye 1/2 hourly</i>		PHARMACY															
SIGNATURE <i>[Signature]</i>		DATE <i>26-10-06</i>		D/C <i>Y</i>		N <i>N</i>											
		DISP ₁		DISP ₂													
APPROVED DRUG NAME <i>PARACETAMOL</i>		DOSE <i>5</i>		ROUTE <i>RO</i>		<i>0800</i>		<i>1200</i>		<i>1600</i>		<i>2000</i>					
INSTRUCTIONS		PHARMACY															
SIGNATURE <i>[Signature]</i>		DATE <i>27/10/06</i>		D/C <i>Y</i>		N <i>N</i>											
		DISP ₁		DISP ₂													
APPROVED DRUG NAME		DOSE		ROUTE													
INSTRUCTIONS		PHARMACY															
SIGNATURE		DATE		D/C		N											
		DISP ₁		DISP ₂													
APPROVED DRUG NAME		DOSE		ROUTE													
INSTRUCTIONS		PHARMACY															
SIGNATURE		DATE		D/C		N											
		DISP ₁		DISP ₂													
APPROVED DRUG NAME		DOSE		ROUTE													
INSTRUCTIONS		PHARMACY															
SIGNATURE		DATE		D/C		N											
		DISP ₁		DISP ₂													
APPROVED DRUG NAME		DOSE		ROUTE													
INSTRUCTIONS		PHARMACY															
SIGNATURE		DATE		D/C		N											
		DISP ₁		DISP ₂													
APPROVED DRUG NAME		DOSE		ROUTE													
INSTRUCTIONS		PHARMACY															
SIGNATURE		DATE		D/C		N											
		DISP ₁		DISP ₂													
APPROVED DRUG NAME		DOSE		ROUTE													
INSTRUCTIONS		PHARMACY															
SIGNATURE		DATE		D/C		N											
		DISP ₁		DISP ₂													
APPROVED DRUG NAME		DOSE		ROUTE													
INSTRUCTIONS		PHARMACY															
SIGNATURE		DATE		D/C		N											
		DISP ₁		DISP ₂													
APPROVED DRUG NAME		DOSE		ROUTE													
INSTRUCTIONS		PHARMACY															
SIGNATURE		DATE		D/C		N											
		DISP ₁		DISP ₂													

Pharmacy Codes: Clin = Professional Clinical Check POD = pt own drugs available and suitable for use D/C = drug to be continued on discharge Disp = Supply dispensed labelled and checked

Initial Date Y N Quantity Y N M S P R T D C A S O I E L S T R I C T I O N S I N T E N T I O N S

NURSING NOTES
 (Also to be used for Short Term
 Patients instead of Nursing Profile)

Surname

Forenames

Address



CHI: 3011795258
 CRN: SZ 237397 30/11/1979
 SCRIMSHAW GARRY M
 43 EASTCASTLE STREET
 ALLOA
 FK10 1BB

COPY

19

Date

EXOCIA (L) EYE 1/2 HELY

DATE	TIME	SIGNATURE
26.10.06	9.30	H. Berry
	10.00	H. Berry
	10.30	H. Berry
	11.00	H. Berry
	11.30	H. Berry
	12.00	H. Berry
27/10/06	00.30	H. Berry
"	01.00	H. Berry
"	01.30	H. Berry
"	02.00	H. Berry
"	02.30	H. Berry
"	03.00	H. Berry
"	03.30	H. Berry
"	04.00	J.M.D.
"	04.30	J.M.D.
"	05.00	H. Berry
"	05.30	H. Berry
"	06.00	H. Berry
"	06.30	H. Berry
"	07.00	
"	07.30	C. Denott
"	08.00	C. Denott
	08.30	C. Denott
	09.00	C. Denott
	09.30	
	10.00	

NURSING NOTES

Write - imprint or Attach Label

Surname Scrimshaw Hospital No. _____

Forenames GARY Sex M

D. of B. 30.11.79

Address _____

COPY

Ward / Dept. 29B

Consultant _____

Date

26.10.06 Admitted to ward 29B via eye clinic. Reported
1.5⁰⁰ hrs to eye clinic by GP with (L) eye injury for
1/2 hourly eye drops. Checked in by Jho. All
observations stable on admission. Settled since
admission for review in the am. SJ Wetherston

27/10/06 Eyedrops given 1/2 hrly throughout night
so patient not had much sleep. Eye
red slightly swollen and weepy. Has been
very uncomfortable overnight. Dihydrocodeine
30mgs given at 02.10. HBimny

Attended eye clinic:
Lens changed to a smaller size.
Eyedrops (ofloxacin) to continue 6x daily.
May be discharged here.
Patient has eye clinic appt for Monday 30/10/06
CWSenolt Fr.

PATIENT PROFILE

Addressograph: Name: <i>CARY Scrimshaw</i> Address: <i>43 EAST Castle STREET</i> <i>Alloa FK10 1BB</i> DoB: <i>30.11.79</i> Unit No: <i>237397</i> Prefers to be addressed as: Age: <i>26</i>		Consultant: Ward: <i>29B</i> Pre-op Date: Date of Admission: Time of Admission: Readmission Date:	
Provisional Diagnosis: <i>(L) eye injury</i> <i>P. corneal abrasion</i>		Final Diagnosis / Treatment:	
Next of Kin: Name: <i>MRS Scrimshaw</i> Address: <i>43 East Castle STREET</i> <i>Alloa.</i> Relationship: <i>wife.</i> Tel. Day: Mobile: <i>07706396071.</i> Tel. Night:		Name: Address: Relationship: Tel. Day: Mobile: Tel. Night:	
G.P. <i>DR Borkard.</i> Practice: <i>Alloa Medical Centre</i> Transport req. for discharge: YES: Ref.No: NO: will collect.		Own Medication: Y: <input checked="" type="radio"/> N: <input checked="" type="radio"/> In Cupboard: Y: <input checked="" type="radio"/> N: <input checked="" type="radio"/> Returned to relatives: Y: <input checked="" type="radio"/> N: <input checked="" type="radio"/>	
Urinalysis: Date: Uroblinogen: Bilirubin: Protein: Sp.Grav: Blood: Glucose: PH: Ketone:		Bladder: <u>Continent/Incontinent:</u> LMP: Pregnancy Test: REQ: YES: N/A: Date:	
Bowel: <i>Normal.</i> BLO: Stoma Nurse Referral: N/A: YES: Date:		Diet: <i>Normal</i> Weight: Kg Appetite: Dietetic Referral: YES: Date: N/A:	
Teeth: Eyesight: } <i>no problems.</i> Hearing: }		Religion: <i>NIK.</i> Marital Status: <i>married</i> Occupation: <i>Chef</i>	
Understanding of Illness / Surgery <p align="center"><i>fully aware</i></p> Patient spoken to by: Relatives spoken to by:			
Admitted by: <i>S.J. WOTHERSPOON</i> Named Nurse on Admission:		Date: <i>26.10.06.</i>	

COPY

General Medication Oral and other routes (regular)

(General Medication starts at page 2 and works forward. Parenteral Medication starts at page 4 and works forward)

- enter dosage times as 24hour clock
- please write in block capitals
- please write in black pen
- Maximum of 3 continuation sheets
- please ensure patient details are on each sheet

COPY

ALLERGIES - Please use RED INK	N K D A (Please circle if appropriate)	DATE →	22/10/10						
(one of these boxes must be filled in)		TIME ↓							

Drug OXYGEN

Circle target oxygen saturation

88-92% 94-98% Other _____

Starting device/flow rate _____

PRN/continuous (refer to O₂ guideline)

Tick here if saturation not indicated*

Date and signature _____

Print name _____

APPROVED DRUG NAME	DOSE	ROUTE	
NILCORNE PATCH	15mg	PLUMS DEWATER	Ⓟ
INSTRUCTIONS	Clin Pharm.	Reg/New	
REMOVE AT NIGHT			
SIGNATURE	DATE	Reason for stopping	
	24/10		

APPROVED DRUG NAME	DOSE	ROUTE	
INSTRUCTIONS	Clin Pharm.	Reg/New	
SIGNATURE	DATE	Reason for stopping	

APPROVED DRUG NAME	DOSE	ROUTE	
INSTRUCTIONS	Clin Pharm.	Reg/New	
SIGNATURE	DATE	Reason for stopping	

APPROVED DRUG NAME	DOSE	ROUTE	
INSTRUCTIONS	Clin Pharm.	Reg/New	
SIGNATURE	DATE	Reason for stopping	

APPROVED DRUG NAME	DOSE	ROUTE	
INSTRUCTIONS	Clin Pharm.	Reg/New	
SIGNATURE	DATE	Reason for stopping	

PHARMACY USE ONLY

SUPPLY

SUPPLY

SUPPLY

SUPPLY

SUPPLY

SUPPLY

SUPPLY

Other Charts in use (Please tick)	Insulin	Anticoagulant	Pain	Additional Kardex	Other
-----------------------------------	---------	---------------	------	-------------------	-------

FORTHVALE DISTRICT SERVICES

MEDICATION PRESCRIPTION & ADMINISTRATION RECORD SHEET

COPY

WARD	PATIENT DETAIL (Name and Address)
AMERGUS	CHI: 3011795258 SCRIMSHAW GARY 7 MOSS ROAD TILLCOUNTRY FK13 6NS
PKDA (Please circle if appropriate)	HOSPITAL
(one of these boxes must be filled in)	DATE OF BIRTH:
Initial here when informed verbal consent to use/destroy POD's is received from the patient.	

Drugs administered prior to hospital arrival

Date	Approved Drug Name	Dose	Route	Given by (e.g. SAS, GP)	Time given
	Naloxone	400µg	IV	SAS	1255h

ONCE ONLY MEDICATION

PHARMACY	DATE	APPROVED DRUG NAME	DOSE	ROUTE	TIME/INSTRUCTIONS	DR SIGNATURE	GIVEN BY	TIME GIVEN
		Sodium bicarbonate 8.4%	50mly			<i>[Signature]</i>	<i>[Signature]</i>	1338

INSTRUCTIONS FOR USING THIS SHEET

<ul style="list-style-type: none"> Doctors and Nurses must ONLY write in black ink (except for allergies) Pharmacists must ONLY use green ink Use the approved drug (RINN) name and write in BLOCK CAPITALS Enter the specified times and write additional information in the instruction box. ONLY use the listed abbreviated routes of administration. Where the abbreviation is not listed, write the route in full. Dose must be stated in either metric or SI units. Quantities less than 1mg must be written in full eg. micrograms. To cancel a drug draw a diagonal line through the entire entry, initial and date. TWO nurses must initial each drug administration for ALL Parenteral and Paediatric Medicine. When a drug is not given - enter the not given code (see list) ALL of the above MUST be adhered to 	<p>ROUTES</p> <ul style="list-style-type: none"> IV - intravenous IM - intramuscular SC - subcutaneous PO - oral INH - inhaled NEB - nebulised SL - sublingual PR - by rectum PV - by vagina TOP - topical 	<p>NOT GIVEN CODES</p> <ol style="list-style-type: none"> Patient not on ward Patient unable to take Patient vomited Drug not available Drug not required Given > 30 mins late (state time) Patient allergy Patient refused Withheld - medical indication Given by Patient/relative/carer
--	---	---

KARDEX C

PHYSICAL ASSESSMENT OF CONDITION/NEEDS	AIMS AND PLANNED CARE
6. Elimination	
Renal function: <i>Urinary catheter in situ - removed at 11:00 AM. Urinary output adequate. U & E's satisfactory</i>	Care of urinary catheter ✓ <i>Hourly Volumes/ Free Drainage</i> Daily urea and electrolytes ✓ <i>Daily Urinalysis</i> ✓
	Aim for a +ve / -ve balance of: <i>neutral</i> Maintain an accurate fluid balance ✓
Renal replacement therapy: Yes (No)	
IV Anticoagulant	Maintain safe / effective renal replacement therapy.
Vascath site:	Care of renal replacement lines / maintain patient safety. } <i>N/A</i> Maintain APPT ratio of:
Drains / Output	
Abdomen Distended (Soft) Bowels last open: <i>pre admission</i>	Prevent Constipation
Colostomy / Ileostomy / Mucoïd Fistula	
Stoma Condition: Appliance Type:	? Refer to Stoma Care Team.

7. Personal	
General body condition: <i>Skin clean & intact</i>	Maintain appropriate hygiene standards and dignity.
Mouth condition:	Bed bath / shave / hair wash / finger nails / toe nails / catheter care ✓ <i>refused shave today</i>
Eye condition: <i>eyes "puffy"</i>	
Arterial Line site: (R) radial - <i>satisfactory</i>	Ensure occlusive dressing is intact to all line sites. ✓
Central Line: (R) I.V. - <i>satisfactory</i>	
Venflon site/s: <i>N/A</i>	
Wound (s): <i>N/A</i>	Redress:
Drains:	Aim for healthy granulation of wounds Reduce Infection

COPY

2. Cardiovascular Care		Aims Maintain Cardiac Stability
Cardiac Rhythm: <i>Sinus Rhythm</i> Rate: <i>80-96</i>		Monitor vital signs and pressure traces frequency ✓
Blood Pressure: NIBP/(APB) <i>160/70</i> MAP: <i>> 90</i>		Change electrodes daily ✓
Inotropes Yes (No):	Type: <i>Removed</i> ✓	12 lead E.C.G. Yes (No)
	Art line position: <i>(R) Radial</i>	Aim for MAP: <i>> 75</i> Aim for CVP: <i>8-12</i>
CVP: <i>+ 10</i>		Titrate Inotropes to ensure set parameters
Temperature: <i>36.2</i>		Care of invasive monitoring lines : Flush Lumens x 1 per shift ✓
		: Flush Prescribed: Yes (No)
		: Record CSM to digits per shift ✓

PHYSICAL ASSESSMENT OF CONDITION/NEEDS	AIMS AND PLANNED CARE
3. Pain/Sedation	
Sedation:	Aim for sedation score: <i>0</i>
Sedation Holiday (Yes) No	<i>Drowsy</i>
Pain: <i>no do pain</i>	Observe for non-verbal signs of pain frequency ✓
	Assess effectiveness of analgesia and characteristics of pain. ✓
	Aim for pain score <i>0</i>
4. Neurological Care	
Neurological State: <i>Drowsy & weepy</i>	Observe for neurological deterioration and report any changes.
Pupils <i>6.5 15</i>	Record GCS AVPU Score x 1 per shift ✓
5. Nutrition/Hydration	
NBM/Feeding (Oral Fluids) Diet Type <i>Normal</i> ✓	Liase with the dietician and the anaesthetist re feeding regime
Feed Enteral / Parenteral	Encourage/ Provide adequate nutrition ✓
Feed Type	Change NG fixing tape daily. <i>N/A</i>
Gastric Aspirates: — PH: —	Record blood glucose <i>DAILY</i> hourly.
	Aim for Blood Glucose: <i>3.8 - 8.5</i> ✓
Blood Sugar: <i>4.5 mmols</i>	Encourage oral fluids / diet supplements: (Yes) No
Sliding scale insulin regime prescribed: Yes (No)	Maintain an accurate fluid balance. ✓
	Weekly weight complete nutritional risk screening tool. ✓

COPY

8. Mobility		Aim
Pressure areas: <u>Intact</u>		Reassess all pressure areas 3-4 hourly.
Sunderland Score / Waterlow		Turning / repositioning required 3-4 hourly.
Mobility: <u>Bed Rest / Up to sit</u>		Therapeutic Mattress: Yes <u>(No)</u> Type:
Teds in situ:	Size: Length:	Manual handling technique: <u>GL + 2 nurses</u>
LMWH <u>(Yes) No</u>	Prescribed:	Mobility Chart Falls Risk Assessment
		Reduce Risk Factors of DVT
9. Infection		
WCC elevated: Yes <u>(No)</u>	<u>8.2</u>	Damp dust bedspace each shift.
		Inform relatives about hand washing
MRSA + ve: Yes / No <u>awaited</u>	Site/s:	
Microbiology	Sites:	
Patient isolation: yes <u>(no)</u>		
10. Psychological / Cultural		Aim
Patient's psychological condition:		Communication tools: lip reading / alphabet / speaking tube <u>N/A</u>
Family: <u>Ex-wife updated by phone</u>		Orientate patient to time, place and person. ✓
Sleep/rest:		Explain all plans procedures to patients and family. ✓
		Give reassurance / support to patient. ✓
Spirituality:		Encourage involvement in decision making. ✓
		Maintain the environment conducive to sleep / rest periods. ✓
		Reduce unnecessary noise / alarms. ✓
		Accommodate religious / cultural / spiritual needs. ✓
		Maximise stimulation when appropriate - visitors
		TV / radio / newspapers / photographs

Day shift assessed by: Margaret C Thomson (Signature) M C THOMSON (PRINT NAME) S/N (Job title) 12⁰⁰ (Time)

Night shift assessed by: _____ (Signature) _____ (PRINT NAME) _____ (Job title)



Critical Care Department Care Plan

NAME:

CHI 3011795258
 CRN: S237397 30/11/1979
 SCRIMSHAW GARRY M
 7 Moss Road,
 TILLCOUNTRY,
 Clackmannanshire
 FK13 6NS.

DAY NO: 2

CRITICAL CARE CONSULTANT(S): D. [unclear]
 REFERRING CONSULTANT: 2

PREFERRED NAME:

CHI NO:

AGE: 30

PREVIOUS 24 HOUR SUMMARY (NIGHT SHIFT TO COMPLETE):

*Ventilated + sedated overnight
 One episode of haemoglobinemic instability - resolved - will further observe
 T_{max} - well up, re-assess.*

DATE: 21/8/2010

All nursing care documented in this care plan, is in accordance with Stirling Royal Infirmary NHS Trust procedures and guidelines and is used in conjunction with the Critical Care patient observation chart. Please delete as appropriate. Document care using a black pen (day duty). Use a green pen (night duty) when changes to patient assessment are found.

PHYSICAL ASSESSMENT OR CONDITION/NEEDS	AIMS AND PLANNED CARE
1. Respiratory Care	
Ventilation: <i>Self-ventilating on R.A.</i>	Maintain patent/airway. Auscultate regularly. Pre-oxygenate: Yes/No
<i>RR 16 - 19 SaO₂ > 95%</i>	Ensure optimum respiratory function / ventilation. ✓
Chest Secretions: <i>nil</i>	Sit Up 45° ✓
Regular Physio: <input checked="" type="radio"/> Yes / <input type="radio"/> No	Aim for SpO ₂ > 93%
Suctioning Required: <input type="radio"/> Yes / <input checked="" type="radio"/> No	Monitor ABG's and act accordingly. ✓
ABG's:	
Tracheostomy: Yes / No	Weaning: Yes / No
	Weaning plan: <i>N/A</i>
Oxygen Therapy: <input checked="" type="radio"/> Yes / <input type="radio"/> No	Prescribed Yes / No
Oxygen Percentage:	Delivery System:
	Reduce risk of lung infection ✓

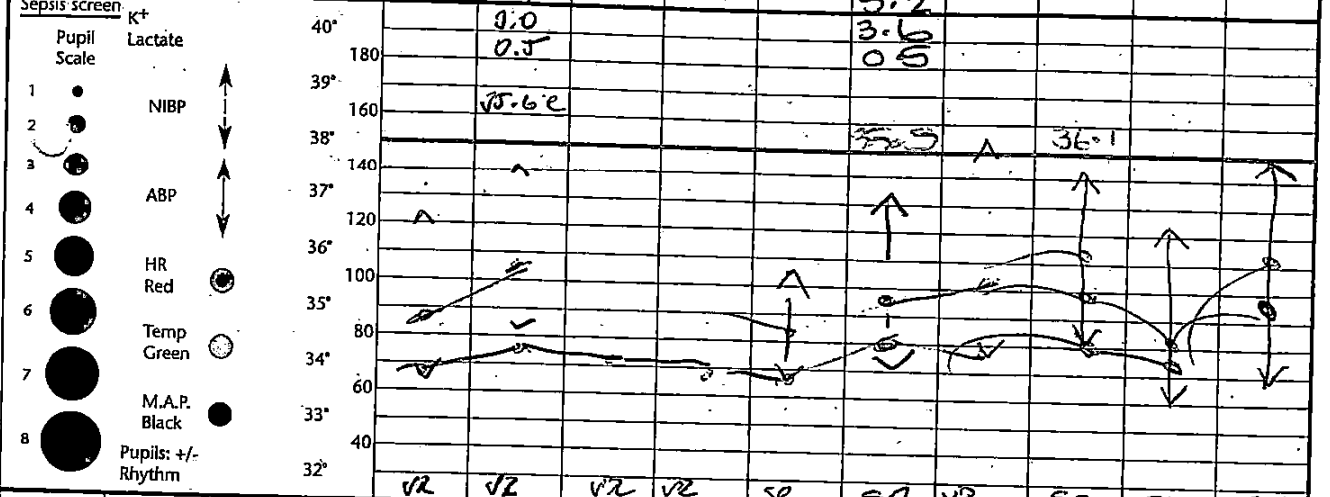
COPY

R E S P I R A T I O N	Vent. Mode	01.00	02.00	03.00	04.00	05.00	06.00	07.00	08.00	09.00	10.00
	FIO ₂	21.0	21.0	21.0	21.0	21.0	21.0	21.0	21.0	21.0	21.0
	Rate/Set/Spont.	15/15	15/15	15/15	15/15	15/15	15/15	15/15	15/15	15/15	15/15
	Press.Support/Cont	15/15	15/15	15/15	15/15	15/15	15/15	15/15	15/15	15/15	15/15
	Peep/CPAP	5	5	5	5	5	5	5	5	5	5
	T.Vol.Exp./I.PAP	551	557	580	604	601	580	397	532	532	532
	M.Vol Exp./E.PAP	609	7.7	7.8	7.8	7.8	7.5	7.9	7.9	7.9	7.9
	Peak Airway PR.	20	20	20	20	20	20	20	20	20	20
	I:E / Humid Temp.	1:1	1:1	1:1	1:1	1:1	1:1	1:1	1:1	1:1	1:1
	Air Entry	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Hrly E.T./O.Ph/S.G. Aspirate										
	O ₂ Sats	96%	98%	97%	99%	98%	97%	97%	97%	97%	93%
	End Tidal CO ₂	4.4	4.4	4.0	3.8	3.8	4.4	4.4	4.4	3.9	

v5L

COPY

A B G S	H+ IONS										
	PCO ₂		32.9				37.6				
	PO ₂		4.06				3.85				
	HCO ₃ S		14.1				14.8				
	BE		19.7				20.5				
	Glucose/BM		-3.8				-2.6				
			5.4				5.2				



CVP	+9	+7	+9	+8	+8	+8	+8	+8	+7	+7
Rass/Pain	4	4	4	4	4	4	4	4	4	4
2 hrly Oral Hygiene	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

I N F U S I O N S	PROVENTIL	2 KR	2 L6	2 L24	2 L22	2 L20	2 L18	2 L16	2 L14	2 L12	2 L11
	Concentration/Pump No.	2	2	2	2	2	2	2	2	2	2
	IV FLUIDS	100	100/20	100/20	100/30	100/42	100/80	100/104	100/215	100/30	100/408
	PROPOFOL	8	8	8	8	8	8	8	8	8	8
	PAVLOVA	32	32	32	32	32	32	32	32	32	32
	mg/kg	16	16	16	16	16	16	16	16	16	16
		14	21	15	14	17					
	Position R/L/B head of bed >30°	2 ✓	L ✓	L ✓	L ✓	R ✓	R ✓	B ✓	B ✓	B ✓	B ✓
	Initials	J	J	J	J	W	N	J	B	B	B

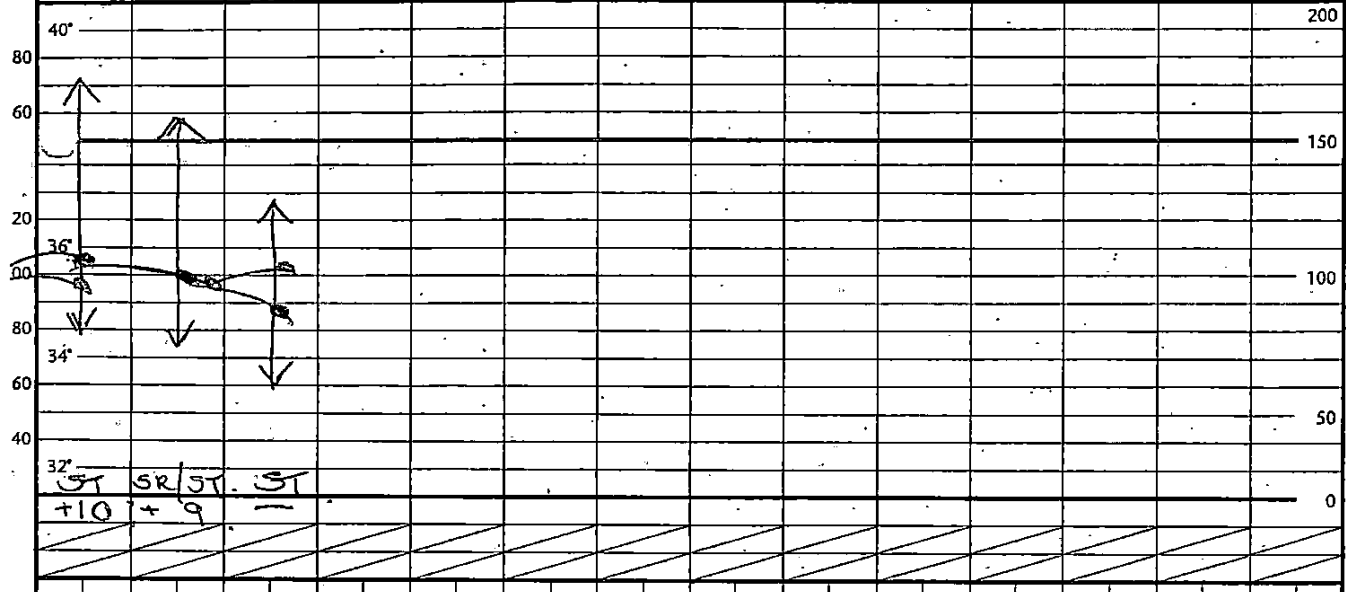
I N	Colloid										
	Drugs			50	50		20	80	50		
	Ng / Oral										
	Hourly Total	52	173	190	199	171	105	199	213	124	149
Running Total	52	225	415	614	785	910	1109	1322	1446	1595	

O U T	Urine	58	80	60	90	35	25	20	35	30	25
	Gastric										
	Bowels / Stoma										
	Drain										
	CWH										
Hourly Total	55	80	60	90	38	25	20	35	30	25	
Running Total	55	135	215	305	340	365	385	420	450	475	
Balance		+90		+309							

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	00.00
SV.	SV	SV											
3L	RA.	RA											
15	14	16											

COPY

95% 95% 94%



100526	DEF	
112		
32350	32349	32343
32	29	34

14) ✓ 31) ✓
b b

150	200
294	34
1889	1918
35	1952

35
510
+1408

Events

01.00	PAC => (2)	COPY	Initials <i>[Signature]</i>
02.00	KCL replacement - 40 mols		
03.00			
04.00			
05.00	Propofol 7 mls/hr - waking up, moving - unresponsive		
06.00	PAC => (2), KCL replacement 2 mols		2
07.00			
08.00	Bad chestes.		No
09.00	Sedation break		
10.00	Extubated at 09.55. RR 19; SaO2 88% -> 96% Flow 5 L/min		No
11.00	Urinary catheter out. Taking oral fluids		1
12.00	Refused lunch.		1
13.00			
14.00			
15.00			
16.00			
17.00			
18.00			
19.00			
20.00			
21.00			
22.00			
23.00			
00.00			

	AM	PM		AM	PM
Admitting team aware Y / N			Does patient have a PVC Y / N (if N go to AB's)		
APACHE II score complete Y / N	NA	NA	New PVC today		
Wardwatcher up to date Y / N			Documentation/sticker completed Y / N		
Is patient ventilated Y / N (if N go to blood sugars)			Is PVC still required Y / N (If N then remove=R)		
HOB > 30° Y / N			Evidence of inflammation / erythema Y / N		
Sedation Holiday appropriate Y / N / LEx / NA			Dressing intact Y / N		
Ventilatory Weaning considered Y / N / LEx			Has PVC been in situ > 72 hours Y / N		
Weaning plan considered Y / N / NA			Is pt on AB's Y / N (if N go to other activities)		
Chlorhexidine prescribed Y / N			Are antimicrobials still required Y / N		
Subglottic aspiration tube Y / N / Lx			Antimicrobials prescribed as per guidelines Y / N		
HMEF appropriate Y / N			Do antimicrobials require de-escalation Y / N		
Is wet circuit required?			Other activities		
Blood sugar - Is insulin required Y / N / LEx			DVT prophylaxis prescribed Y / N		
Is Insulin prescribed Y / N			Peptic ulcer prophylaxis prescribed Y / N / LEx		
Does patient have a central line Y / N (if N go to sepsis)			Patient up to sit Y / N / Lx		
New CVC line today Y / N			Daily goals / Plan written in medical notes		
Documentation completed Y / N			Kardex reviewed and re written as required Y / N		
Is CVC still required Y / N - If N remove (R) & send Tip for C&S			Blood results reviewed and actioned Y / N		
Is dressing intact Y / N			Assessed as per mobility chart Y / N		
Sepsis Screen - Is patient pyrexia Y / N			Is patient ready for discharge Y / N		
Has sepsis screen been completed Y / N			Receiving informed of discharge Y / N / NA		
Are there outstanding microbiology results Y / N			Discharge planning complete Y / N		
MRSA eradication therapy required Y / N			Discharge documentation completed Y / N		

Y = Yes N = No LEx = Local Exclusion NA = Not Applicable

Nursing Evaluation Cont.

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- ① Night Report: ① PO_2 weaned overnight to 21%, RR 6 13 bpm due to ↓ CO_2 will alter changes in ventilation.
- ② RR 20 bpm, normoventilator, Temp 37.5 - 38.0 adequate oximetry in situ.
- ③ Propofol 7 10 ul/hr => wakening up - unresponsive, at risk of self-extubation.
- ④ Waking up, ROS (moves all limbs), presence of consciousness.
- ⑤ NBT on free drainage overnight - 200 uls out. BUN 14, 14 fluids + Patroxon overnight.
- ⑥ Allergate 4/10.
- ⑦ Regular oral care q. - nurse dg. Both nipples uninvolved. Drugs on progress in situ (just uninvolved). NPO, replacement uninvolved, all replacement. PD nurse a total message.
- ⑧ If hospitalized @ 20% - hypotension by meeting tomorrow, appeared he wishes to be the only part of contact. Depressed worries re-yesterday. Giving mental health prior to DD - feels it will be well addressed. All care given given.

Day Report:

Condition improved over morning, extubated and now S/V on R.A. RR 14-20 SpO₂ 95%. C.V.S stable Apyrexial. Central line = A-line can be removed when venflon inserted.

No c/o pain. Remains drowsy and "weepy" at times. Oral fluids and diet as desired. H.N.P.V. since catheter removed. Wife has visited.

C/n transferred to Ward when bed available. To have ~~psych~~ psych review before discharge. (THOMSON) 3/10

3:45 pm. Central line removed, lip sent for CRS. Pink venflon inserted. Tried to get out of bed & stumbled but caught by wife before he hurt himself. Becoming more talkative and wanting to go home.

8. Mobility		Aim
Pressure areas: <i>upper heel</i>		Reassess all pressure areas <i>4</i> hourly.
Sunderland Score / Waterlow / <i>Boden</i>		Turning / repositioning required <i>4</i> hourly.
Mobility: <i>Bed Rest / Up to sit</i>		Therapeutic Mattress: Yes / <i>No</i> Type:
Teds in situ: <i>spacers</i> Size: Length:		Manual handling technique:
LMWH: Yes / <i>No</i> Prescribed: <i>✓</i>		Mobility Chart Falls Risk Assessment
		Reduce Risk Factors of DVT
9. Infection		
WCC elevated: Yes / <i>No</i>		Damp dust bedspace each shift.
		Inform relatives about hand washing
MRSA + ve: Yes / <i>No</i> <i>performed</i> Site/s:		
Microbiology Sites:		
Patient isolation: yes / <i>No</i>		
10. Psychological / Cultural		Aim
Patient's psychological condition: <i>Severely frustrated</i>		Communication tools: lip reading / alphabet / speaking tube
Family: <i>in wife visited & updated</i>		Orientate patient to time, place and person.
Sleep/rest: <i>day / night machine</i>		Explain all plans procedures to patients and family.
Spirituality: <i>Not discussed</i>		Give reassurance / support to patient.
		Encourage involvement in decision making.
		Maintain the environment conducive to sleep / rest periods.
		Reduce unnecessary noise / alarms.
		Accommodate religious / cultural / spiritual needs.
		Maximise stimulation when appropriate - visitors
		TV / radio / newspapers / photographs

Day shift assessed by: *M Cold* (Signature) *M CORKIN* (PRINT NAME) *SCN* (Job title) *17³⁰* (Time)

Night shift assessed by: *J. WARD* (Signature) *G. DAWSON* (PRINT NAME) *WNY* (Job title) *6:00* (Time)

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Critical Care Department Care Plan

2. Cardiovascular Care		Aims Maintain Cardiac Stability
Cardiac Rhythm: <i>ST</i>	<i>100</i> Rate: <i>100-110</i>	Monitor vital signs and pressure traces frequency <input checked="" type="checkbox"/>
Blood Pressure: NIBP (<i>APB</i>)	MAP:	Change electrodes daily
<i>episode of hypotension ? cause</i>	Type:	12 lead E.C.G. <input checked="" type="checkbox"/> <i>done in A+E</i>
Inotropes Yes/No:	Art line position: <i>RRA</i>	Aim for MAP: <i>80</i> Aim for CVP: <i>N/A</i>
CVP: <i>for 9L motion. +8 - +14</i>		Titrate Inotropes to ensure set parameters
Temperature: <i>35.5 - 35.7 °C</i>		Care of invasive monitoring lines : Flush Lumens x 1 per shift <input checked="" type="checkbox"/>
		: Flush Prescribed: Yes/No
		: Record CSM to digits per shift


PHYSICAL ASSESSMENT OF CONDITION/NEEDS		AIMS AND PLANNED CARE
3. Pain/Sedation		
Sedation: <i>RASS = -5</i>		Aim for sedation score: <i>RASS = 0</i>
Sedation Holiday <i>Yes/No N/A</i>		
<i>Propofol Albuterol response in progress</i>		
Pain: <i>No obvious signs of pain / discomfort</i>		Observe for non-verbal signs of pain frequency
		Assess effectiveness of analgesia and characteristics of pain. <input checked="" type="checkbox"/>
		Aim for pain score
4. Neurological Care		
Neurological State: <i>PRLL 4+/4+</i>		Observe for neurological deterioration and report any changes.
Pupils		Record GCS AVPU Score x 1 per shift 14
5. Nutrition/Hydration		
NBM/Feeding / Oral Fluids / Diet Type		Liase with the dietician and the anaesthetist re feeding regime
Feed Enteral / Parenteral	Tube type: Ryles / Fine Bore	Encourage / Provide adequate nutrition
Feed Type	Position:	Change NG fixing tape daily.
<i>? for N/G tube</i>	<i>BY BONE</i>	
Gastric Aspirates: PH: <i>DEAD/NOISE</i>		Record blood glucose <i>2-3</i> hourly.
		Aim for Blood Glucose: 3.8 - 8.5
Blood Sugar: <i>as checked</i>		Encourage oral fluids / diet supplements: Yes/No <input checked="" type="checkbox"/>
Sliding scale insulin regime prescribed: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <i>NOT PRESCRIBED</i>		Maintain an accurate fluid balance.
		Weekly weight complete nutritional risk screening tool.

Critical Care Department Care Plan

COPY

PHYSICAL ASSESSMENT OF CONDITION/NEEDS	AIMS AND PLANNED CARE
6. Elimination	
Renal function: <i>Ureter catheter (Size 16 / 10 ml in balloon)</i> <i>meted every aseptic technique</i>	Care of urinary catheter Hourly Volumes / Free Drainage Daily urea and electrolytes Daily Urinalysis
<i>Good urine output</i>	Aim for a +ve / -ve balance of: Maintain an accurate fluid balance
Renal replacement therapy: Yes / <input checked="" type="radio"/> No	
IV Anticoagulant	Maintain safe / effective renal replacement therapy.
Vascath site:	Care of renal replacement lines / maintain patient safety. Maintain APPT ratio of:
Drains / Output	
Abdomen Distended <input checked="" type="radio"/> Soft Bowels last open:	Prevent Constipation
Colostomy / Ileostomy / Mucoid Fistula	
Stoma Condition: Appliance Type:	? Refer to Stoma Care Team.
7: Personal	
General body condition: <i>Satisfactory</i>	Maintain appropriate hygiene standards and dignity.
Mouth condition: <i>Dry</i>	Bed bath / shave / hair wash / finger nails / toe nails / catheter care
Eye condition: <i>OK</i>	
Arterial Line site: <i>OK</i>	Ensure occlusive dressing is intact to all line sites.
Central Line: <i>OK</i>	
Venflon site/s: <i>Satisfactory => non-wired</i>	
Wound (s): <i>n/a</i>	Redress:
Drains:	Aim for healthy granulation of wounds Reduce Infection

Critical Care Department Care Plan

NAME: 
 CHI: 3011785258
 CRN: S237397 30/11/1979
 PREFERR: SCRIMSHAW GARRY M
 7 Moss Road,
 TILLCOUNTRY,
 Clackmannanshire
 CHI NO: FK13 6NS

DAY NO: ①
 CRITICAL CARE CONSULTANT(S): De Maie
 REFERRING CONSULTANT:

OF BIRTH: AGE:

PREVIOUS 24 HOUR SUMMARY (NIGHT SHIFT TO COMPLETE):

Admitted from A&E following an overdose of tricyclic antidepressants & paracetamol
 + GCS - requiring intubation & ventilation.

DATE: 20/8/10

All nursing care documented in this care plan, is in accordance with Stirling Royal Infirmary NHS Trust procedures and guidelines and is used in conjunction with the Critical Care patient observation chart. Please delete as appropriate. Document care using a black pen (day duty). Use a green pen (night duty) when changes to patient assessment are found.

PHYSICAL ASSESSMENT OF CONDITION/NEEDS	AIMS AND PLANNED CARE
1. Respiratory Care	
Ventilation: On ASIMV FiO ₂ 50% PEEP = 15 ; PEEP + 5 SaO ₂ > 94% ; FiO ₂ ↓ 21%	Maintain patent airway. Auscultate regularly. Pre-oxygenate: Yes/No Ensure optimum respiratory function/ventilation.
Chest Secretions: Nil	Sit Up 45° ✓
Regular Physio Yes / No	Aim for SpO ₂ > 94%
Suctioning Required Yes / No	Monitor ABG's and act accordingly. ✓
ABG's: as checked.	
Tracheostomy: Yes / (No)	Weaning: (Yes) / No Aim to reduce FiO ₂ / PEEP
	Weaning plan: as abt
Oxygen Therapy Yes / No	
Prescribed Yes / No	
Oxygen Percentage:	Delivery System:
	Reduce risk of lung infection 100% provided

COPY

Patient Name

CHI 3011795258
 CRN: S237397 30/11/1979
SCRIMSHAW GARRY
 7 Moss Road,
 TILLCOUNTRY,
 Clackmannanshire
 FK13 6NS



Has the patient fallen in the past year: Yes / No
 Is the patient over 65 years of age: Yes / No
 If yes to any of the above:

- complete the falls risk assessment chart
- refer to physiotherapist as soon as possible
- supervise patients mobility
- provide a wheeled zimmer for patients use (refer to checklist on action plan)

Yes
 Yes
 Yes
 Yes / No

Unit Number

Ward/Dept..... Weight.....

Date	Ops 2/3/4	No of Staff	No of Staff	No of Staff	No of Staff	No of Staff	No of Staff	No of Staff	No of Staff	No of Staff	No of Staff	Comments
Transfer	R40	2/3										
Move up bed	R40	2/3										
Turning in bed	BR	—										
Lying → sitting over edge of bed	BR	—										
Sit to Stand	PS	4										
Trolley → bed	CANISTER YES											
Toileting	BB	2										
Bathing	BR	—										
Walking												
Signature/Initial	M. G. R.											

Codes

- Independent
- Supervised
- Requires Help of
- Hoist (specify)
- Standaid
- Bedrest
- Other -

Assistance Required

- Ind
- Sup
- 1/2/3/4...
- H
- S
- BR
- Specify

Method of Assistance

- Glide Sheet GS
- Multimover MM
- Folding Back Rest FBR
- Posterior Hold PH
- Combination Hold CH
- Patslide/Rollerboard PS/RB
- Other - Specify


Mobility and mobility aids

- NM not to be mobilised
- NWB Non weight bearing
- PWB Partial Weight bearing
- FWB Full Weight bearing
- Walking Sticks WS
- Mobilator M
- Gutter Rollator GR
- Wheelchair W

Zimmer
 Delta Rollator
 Clutches
 DR
 C



COPY


 CHI:3011795258
 CRN:S237397 30/11/1979
SCRIMSHAW GARRY M
 7 Moss Road
 TILLCOUNTRY,
 Clackmannanshire
 FK13 6NS

Bradford Risk Assessment Chart

Individuals with a total score of 16 or less are considered at risk:
 15 - 16 = low risk, 13 - 14 = moderate risk, 12 or less = high risk.

Undertake and document risk assessment within 6 hours of admission or on first home visit.
 Reassess if there is a change in individual's condition and repeat regularly according to local protocol

Date:


Sensory Perception - Ability to respond meaningfully to pressure related discomfort	1. Completely Limited Unresponsive (does not moan, flinch or grasp) to painful stimuli, due to diminished level of consciousness or sedation. OR limited ability to feel pain over most of body surface.	2. Very Limited Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness. OR has a sensory impairment that limits the ability to feel pain or discomfort over 1/2 of body.	3. Slightly Limited Responds to verbal commands, but cannot always communicate discomfort or need to be turned. OR has some sensory impairment that limits ability to feel pain or discomfort in 1 or 2 extremities.	4. No Impairment Responds to verbal commands. Has no sensory deficit that would limit ability to feel or voice pain or discomfort.	1
Moisture - Degree to which skin is exposed to moisture	1. Constantly Moist Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient/client is moved or turned.	2. Very Moist Skin is often, but not always, moist. Linen must be changed at least once a shift.	3. Occasionally Moist Skin is occasionally moist, requiring an extra linen change approximately once a day.	4. Rarely Moist. Skin is usually dry. Linen only requires changing at routine intervals.	3
Activity - Degree of physical activity	1. Bedfast Confined to bed.	2. Chairfast Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	3. Walks Occasionally Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. Walks Frequently Walks outside the room at least twice a day and inside the room every 2 hours during waking hours.	1
Mobility - Ability to change and control body position	1. Completely Immobile Does not make even slight changes in body or extremity position without assistance.	2. Very Limited Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	3. Slightly Limited Makes frequent though slight changes in body or extremity position independently.	4. No limitations Makes major and frequent changes in position without assistance.	7

Infection Surveillance Documentation

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Routine sampling on days documented, samples should be taken out with these days as clinical condition requires.

- Please document date and time of sample collection for routine samples.
- Samples taken at other times require date, time and site of sampling recorded.

Sunday .....(date)	Inse  CHI 3011795258 CRN: S237397 30/11/1979 SCRIMSHAW GARRY M 7 Moss Road, TILlicOUNTRY, Clackmannanshire FK13 6NS
Monday .....(date) Routine MRSA screen (complete separate form with all sample sites) Tracheal Aspirate / Sputum. CSU	Tuesday .....(date)
Wednesday .....(date) Tracheal Aspirate / Sputum. CSU	Thursday .....(date)
Friday 20/8/10 .....(date) Tracheal Aspirate / Sputum. CSU MRSA screen	Saturday 21/8/10 .....(date) A line hp ✓ CVP line hp ✓

Routine admission sampling:

- CSU / Tracheal Asp or sputum /
- Wound / open skin sites for C & S.
- MRSA screen: nose / throat / axilla / groin plus all open skin sites.

The MRSA screen must be completed within 48 hours of admission as any positive results after this time are considered Hospital Acquired Infections and therefore ICU acquired.

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INTENSIVE THERAPY UNIT

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CHI 2011795258
CRN: S237397 30/11/1979
SCRIMSHAW GARRY
7 Moss Road,
TILLCOUNTRY,
Clackmannanshire
FK13 6NS

MRSA SCREENING RECORD

All ITU patients will be screened on admission and thereafter on a weekly basis. Additional screening should only be taken at a minimum interval of 48 hours after treatment has been discontinued. A further 2 full screens should be taken at intervals of no less than 48 hours between each screen. 3 full consecutive sets of screening swabs are required before the patient is considered free of MRSA carriage. [Infection Control Manual, SRI NHS Trust, September 2000]. Specimens are sent to microbiology accompanied by "white" form.

PLEASE TICK THE APPROPRIATE SPECIMEN BOX BELOW

SPECIMEN	20/8/10 Date	Result	Action	Date	Result	Action	Date	Result	Action
Nose - both nostrils	✓								
Throat	✓								
Axilla - 1 swab for both	✓								
Groins - 1 swab for both	✓								
CSU	CRS								
Tracheal secretions	CRS								
Invasive sites:									
1) Arterial Line	.....	.....	.....	.....	.....	.....	.....	.....	.....
2) Central line	.....	.....	.....	.....	.....	.....	.....	.....	.....
3) CVVH Line	.....	.....	.....	.....	.....	.....	.....	.....	.....
4) PA Catheter	.....	.....	.....	.....	.....	.....	.....	.....	.....
5) Venflon 1	.....	.....	.....	.....	.....	.....	.....	.....	.....
6) Venflon 2	.....	.....	.....	.....	.....	.....	.....	.....	.....
7) Venflon 3	.....	.....	.....	.....	.....	.....	.....	.....	.....
8).....	.....	.....	.....	.....	.....	.....	.....	.....	.....
Wound/Skin Lesions:									
1) Abdo wound	.....	.....	.....	.....	.....	.....	.....	.....	.....
2) Trache site	.....	.....	.....	.....	.....	.....	.....	.....	.....
3) Stoma	.....	.....	.....	.....	.....	.....	.....	.....	.....
4) Drain 1	.....	.....	.....	.....	.....	.....	.....	.....	.....
5) Drain 2	.....	.....	.....	.....	.....	.....	.....	.....	.....
6).....	.....	.....	.....	.....	.....	.....	.....	.....	.....
7).....	.....	.....	.....	.....	.....	.....	.....	.....	.....
8).....	.....	.....	.....	.....	.....	.....	.....	.....	.....

RE-SCREEN DATES IF MRSA POSITIVE

Date 1:

Date 2:

Date 3:

FORTH VALLEY ACUTE HOSPITALS
Infusion Fluids / Blood Products Page



WARD		CONSULTANT	
ALLERGIES - Please use RED INK			
HEIGHT (m)	WEIGHT (kg)	DATE	SURFACE AREA (m ²)

PATIENT DATA	CHI: 3011795258	30/11/1979	M
SCRIMSHAW GARY 7 MOSS ROAD TILLCOUNTRY FK13 6NS			
HOSPITAL No:	FK13 6NS		
DATE OF BIRTH:	AGE:		

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- enter dosage times as 24hour clock
- please write in block capitals in black pen
- IV site MUST be checked prior to and after IV administration

A	APPROVED DRUG NAME	DOSE	ROUTE	START TIME	INFUSION STARTED BY:
INFUSION FLUID		TOTAL VOLUME		TIME STARTED	
N. Saline 0.9%		1000		1335	W. Whyte
DOCTORS SIGNATURE	DATE	RATE		PUMP NO.	BATCH NO.
<i>[Signature]</i>	20/8/10	STAT			100111111 03/10

B	APPROVED DRUG NAME	DOSE	ROUTE	START TIME	INFUSION STARTED BY:
INFUSION FLUID		TOTAL VOLUME		TIME STARTED	
N. Saline 0.9%		500		1405	W. Whyte
DOCTORS SIGNATURE	DATE	RATE		PUMP NO.	BATCH NO.
<i>[Signature]</i>	20/8/10				10E211111 04/10

C	APPROVED DRUG NAME	DOSE	ROUTE	START TIME	INFUSION STARTED BY:
INFUSION FLUID		TOTAL VOLUME		TIME STARTED	
DOCTORS SIGNATURE	DATE	RATE		PUMP NO.	BATCH NO.

D	APPROVED DRUG NAME	DOSE	ROUTE	START TIME	INFUSION STARTED BY:
INFUSION FLUID		TOTAL VOLUME		TIME STARTED	
DOCTORS SIGNATURE	DATE	RATE		PUMP NO.	BATCH NO.

E	APPROVED DRUG NAME	DOSE	ROUTE	START TIME	INFUSION STARTED BY:
INFUSION FLUID		TOTAL VOLUME		TIME STARTED	
DOCTORS SIGNATURE	DATE	RATE		PUMP NO.	BATCH NO.

F	APPROVED DRUG NAME	DOSE	ROUTE	START TIME	INFUSION STARTED BY:
INFUSION FLUID		TOTAL VOLUME		TIME STARTED	
DOCTORS SIGNATURE	DATE	RATE		PUMP NO.	BATCH NO.

G	APPROVED DRUG NAME	DOSE	ROUTE	START TIME	INFUSION STARTED BY:
INFUSION FLUID		TOTAL VOLUME		TIME STARTED	
DOCTORS SIGNATURE	DATE	RATE		PUMP NO.	BATCH NO.

H	APPROVED DRUG NAME	DOSE	ROUTE	START TIME	INFUSION STARTED BY:
INFUSION FLUID		TOTAL VOLUME		TIME STARTED	
DOCTORS SIGNATURE	DATE	RATE		PUMP NO.	BATCH NO.

Wound / Stoma / Drains: N/A

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General Body Condition: No problems.

Mobility: no Problems

Infection Status: Awaiting MRSA screen results. WCC normal

Today's Blood Results:

Na	138	Urea	3.0	HB	120	PT/Control	11/11.5
K+	3.7	Creatinine	89	WCC	8.2	APTT/Control	27/31
Chloride	111			Platelets	182	Fibrinogen	1.8

Patient and relatives understanding of health and ongoing care: Fully updated

Any Other Relevant Details: Awaiting psychiatric review.

Discharge Checklist:

Case notes:	
Date of blood transfusion added to case notes:	
Leaflet re blood transfusion given to patient:	
Nursing notes:	
X-Rays:	
Patient's own medication:	
Patient's belongings / clothing list completed:	
Check ward safe:	
Next of kin informed:	
Computer data completed:	

Patient ready for HDU / Ward transfer

Transferring Nurse: Margaret Thomson

Date: 21/8/10

Date: «EPISODE_DISCHARGE_DATE»

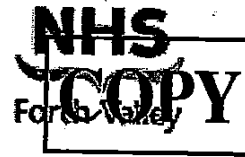
Name: Mr Garry Scrimshaw

Date of Birth: 30/11/1979

CHI No: 3011795258

Patient Nursing Transfer from Critical Care

Nursing Summary



Patient Details	GP Details
Patient CHI No: 3011795258	Practice Code: 25031
Patient Name: Mr Garry Scrimshaw	GP Name: Dr David S Borland
Date of Birth: 30/11/1979	GP Address: Health Centre Practice 3, Hallpark Road, Sauchie, FK10 3JQ
Address: 7 Moss Road,, Tillicoultry,, Clackmannanshire, FK13 6NS	

Consultant: Paterson, Dr Stuart
Date admitted to ICU / HDU: 20/08/2010
Date discharged from ICU / HDU: 21/08/2010

Details of Stay in ICU / HDU: Intubated for airway management. Ventilated overnight. Given IV Parvolex as per regime.

Patient Details at Time of Discharge:

Respiratory: Extubated at 09:30. Now self ventilating on room air.

Cardiovascular: Sinus rhythm. Normotensive.

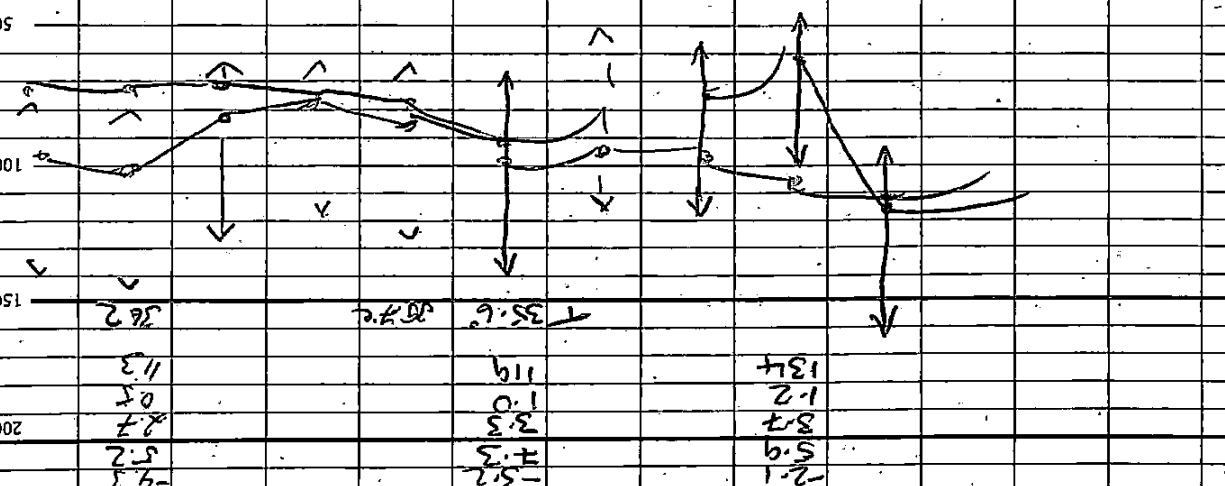
Pain sedation: No sedation. Takes diclofenac and paracetamol for back pain

Neurological: GCS 15

Nutrition / Hydration: Free fluids and diet.

Elimination: Urinary catheter removed this a.m. still to pass urine.

Time	Position	Altitude	Distance	Direction	Speed	Time	Position	Altitude	Distance	Direction	Speed
11:00	15.0	50%	15.0	→	15.0	11:00	15.0	50%	15.0	→	15.0
12:00	15.0	50%	15.0	→	15.0	12:00	15.0	50%	15.0	→	15.0
13:00	15.0	50%	15.0	→	15.0	13:00	15.0	50%	15.0	→	15.0
14:00	15.0	50%	15.0	→	15.0	14:00	15.0	50%	15.0	→	15.0
15:00	15.0	50%	15.0	→	15.0	15:00	15.0	50%	15.0	→	15.0
16:00	15.0	50%	15.0	→	15.0	16:00	15.0	50%	15.0	→	15.0
17:00	15.0	50%	15.0	→	15.0	17:00	15.0	50%	15.0	→	15.0
18:00	15.0	50%	15.0	→	15.0	18:00	15.0	50%	15.0	→	15.0
19:00	15.0	50%	15.0	→	15.0	19:00	15.0	50%	15.0	→	15.0
20:00	15.0	50%	15.0	→	15.0	20:00	15.0	50%	15.0	→	15.0
21:00	15.0	50%	15.0	→	15.0	21:00	15.0	50%	15.0	→	15.0
22:00	15.0	50%	15.0	→	15.0	22:00	15.0	50%	15.0	→	15.0
23:00	15.0	50%	15.0	→	15.0	23:00	15.0	50%	15.0	→	15.0
00:00	15.0	50%	15.0	→	15.0	00:00	15.0	50%	15.0	→	15.0



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Events

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Initials

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	Transfer to ICU - Urinary catheter inserted	M
16.00	+ 50/30, HC + 70; long practice + long Metronidazole give	M
17.00	CL infection ✓	
18.00		
19.00	PRN care taken over.	
20.00	Safety checks ✓ admission ✓	J
21.00		
22.00	TRAC → (C), FIO ₂ & UFI, Present PR & 13	J
23.00	KLL wounds + NfBO4 20 wounds	J
00.00		

	AM	PM		AM	PM
Admitting team aware Y / N			Does patient have a PVC Y / N (if N go to AB's)		
APACHE II score complete Y / N	NA	NA	New PVC today		
Wardwatcher up to date Y / N			Documentation/sticker completed Y / N		
Is patient ventilated Y / N (if N go to blood sugars)			Is PVC still required Y / N (if N then remove=R)		
HOB > 30° Y / N			Evidence of inflammation / erythema Y / N		
Sedation Holiday appropriate Y / N / LEx / NA			Dressing intact Y / N		
Ventilatory Weaning considered Y / N / LEx			Has PVC been in situ > 72 hours Y / N		
Weaning plan considered Y / N / NA			Is pt on AB's Y / N (if N go to other activities)		
Chlorhexidine prescribed Y / N			Are antimicrobials still required Y / N		
Subglottic aspiration tube Y / N / Lx			Antimicrobials prescribed as per guidelines Y / N		
HMEF appropriate Y / N			Do antimicrobials require de-escalation Y / N		
Is wet circuit required?			Other activities		
Blood sugar - Is insulin required Y / N / LEx			DVT prophylaxis prescribed Y / N		
Is Insulin prescribed Y / N			Peptic ulcer prophylaxis prescribed Y / N / LEx		
Does patient have a central line Y / N (if N go to sepsis)			Patient up to sit Y / N / Lx		
New CVC line today Y / N			Daily goals / Plan written in medical notes		
Documentation completed Y / N			Kardex reviewed and re written as required Y / N		
Is CVC still required Y / N - If N remove (R) & send Tip for C&S			Blood results reviewed and actioned Y / N		
Is dressing intact Y / N			Assessed as per mobility chart Y / N		
Sepsis Screen - Is patient pyrexia Y / N			Is patient ready for discharge Y / N		
Has sepsis screen been completed Y / N			Receiving informed of discharge Y / N / NA		
Are there outstanding microbiology results Y / N			Discharge planning complete Y / N		
MRSA eradication therapy required Y / N			Discharge documentation completed Y / N		

Y = Yes

N = No

Lex = Local Exclusion

NA = Not Applicable

Night Report:

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Day Report:

1/ Ventilation - Continues on P-SIMV, FiO_2 at 35%, otherwise settings unchanged
 $SpO_2 > 97\%$

A/E available throughout all lung fields - minimal yield of mucopurulent secretions on suctioning

ABG's on dated

2/ Cardiovascularly labile at times; x1 episode of hypotension; has had slow bolus of calcium gluconate, no inotropic support required at present

HR 80-120 bpm, monitoring in sinus rhythm (12 lead ECG completed)

3/ T of dress - 4/5, on Pampul / Alferhos. I. infusions in progress.

4/ N/G tube in situ - ? for enteral feed - Rm, stable
 furosemid infusion in progress, Na HCO₃ infusion in progress

6/ Good diuresis

7/ + s/ Perine area intact.

9/ Nil new MRSA swab obtained

0/ Family into visit this evening

SEN. M. GILL
 M. COCKSON

Critical Care Unit

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Date: 20/8/10	Day No: ①	D.O.B.	Surname
Date of Admission: 20/8/10	First Name		CHI:3011795258
Diagnosis: OVERDOSE OF TRICHLICIL ANTIDEPRESSANT ↓ GCS.	Address		CRN:S237397 30/11/1979 SCRIMSHAW GARRY M 7 Moss Road, TILLCOUNTRY, Clackmannanshire FK13 6NS
Critical Care Consultant: Dr MAIR.	Referring Consultant:		30 yes

Ventilator: GALIED	Fluid Balance	
Date Ventilation started: O/A.	Intake	Output
Date Ventilation finished:	Oral	Urine
E/T Tube Length at Lips: 22cm. <u>subglottic drain</u> <u>non-subglottic drain</u>		Gastric
Trachy - Inner tube change		Bowel/Stoma
Cuff Pressure: 8am 2pm 8pm 2am 6cm H ₂ O		Drain 1
NG Tube Length at Nose:	Total in	Drain 2
CVWH Commenced	Previous 24 Hour Balance:	Drain 3
CVWH Discontinued	Total out	Cummulative Balance:
MRSA status <i>Screening</i> Site:	Daily Plan:-	
Day Nurse	Night Nurses: 00.00 - 08.00	
Urinalysis	20.00 - 08.00 <i>gm</i>	

CVC Maintenance Bundle *NEW INSERTED TODAY*

12hrly Ventilation Screen

Is CVC still required?	Y / N	D	N
<small>If NO then remove & send tip for C&S. Aseptic technique for procedure.</small>			Y
Is CVC dressing intact?	Y / N		Y
<small>If NO or older than 7 days re-dress. Aseptic technique for procedure.</small>			
Insertion site very inflamed or pus present?	Y / N		N
<small>If YES seek advice, remove line, send tip for C&S. Aseptic technique for procedure.</small>			
CVC Bungs insitu > 3 days?	Y / N		NEW
<small>If YES change bungs & 3-way taps. Aseptic technique for procedure.</small>			

Reduce support using ventilation management Flow Chart

Yes / No (see exclusions below)

- *Cooling
- *Head injury
- *Airway issue

Appropriate to switch off / reduce sedation? (see exclusions)	D	N
SaO ₂ (Target 94%)		Y
FiO ₂ < 0.35?		Y
Secretions manageable?		X
Adequate cough?		N
RSB Index < 100? (F+ Vr)		Y
PEEP ≤ 5?		X
Tube comp on?		Y
Haemoglobin > 70?		Y

Aseptic Technique =

1. Level 2 hand wash
2. Dressing pack & sterile gloves
3. Chlorhexidine 2%

Sepsis Screen if temp > 38° (unless screened in last 48hrs)	Microbiology Results
Peripheral Blood Cultures:	
C.S.U.:	
E.T. Aspirate:	
Other Sites:	

Low Risk Nutritional Care Plan

NHS

Forth Valley
COPY

Patient Details (or attach ID label)

Name :

CHI: 3011795256
SCRIMSHAW

30/11/1979 M

D.O.B :

Garry
7 MOSS ROAD,
TILLCOUNTRY,
FK13 6NS

Unit/CH


Date: 21.8.10

Completed by: J. Reid

Low Risk Actions	✓
<p>Low Risk Set treatment aims:</p> <ul style="list-style-type: none"> • Weight maintenance • Maintain current nutritional intake 	<p>✓ ✓</p>
<p>Actions</p> <ul style="list-style-type: none"> • Provide help and advice on food choices, eating and drinking if required. • Repeat Screening on Sunday or if condition deteriorates. 	<p>✓ ✓</p>
<p>Refer to the dietitian if:</p> <ul style="list-style-type: none"> • Enteral Feeding is required • Specialist dietary advice is required following a diagnosis of Type 1 diabetes, renal disease, Coeliac disease. • Consistency modified diet is required e.g. smooth, soft/moist. • Patient has pressure sores grade 3 or over. • Patient has multiple fractures. 	<p>✓ ✓ ✓ ✓ ✓</p>

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MUST - Nutritional Risk Screening

Patient Details (or attach ID label)  Name: CHI: 3011795258 30/11/1979 M SCRIMSHAW D.O.B.: Garry 7 MOSS ROAD, TILlicOUNTRY, Unit/CI FK13 6NS	Ward: ...ONE..... Date of Admission: ...21.8.10..... Normal weight: ...10st 8... Source:.....
--	---

Step 1 BMI	Weight (kg)	Measured	Height (m)	Measured	BMI (see chart)	Step 1 Score (circle)
	67.25	Reported	5'4	Reported	27	
		Estimated (circle)		Estimated (circle)		> 20 = 0 18.5-20 = 1 < 18.5 = 2
Step 2 Weight Loss over last 3-6 months	Wt Loss * (kg)	Measured	% Change (see chart)		Step 2 Score (circle)	
	31b	Reported	< 5%			
		Estimated (circle)			< 5% = 0 5-10% = 1 > 10% = 2	
* this refers to the total unplanned weight loss over the last 3 - 6 months						
Step 3 Acute Disease Effect	Acute illness AND there has been, or is likely to be, no nutritional oral intake for 5 days				Step 3 Score (circle)	
	Not NBM = score 0 NBM = score 2				0 2	
Step 4 Overall Risk Score	Add scores from Steps 1 + 2 + 3 = Total				Total Score: 0	
Step 5 Management	Develop and Implement appropriate Nutritional Care Plan				Nutritional Care Plan (circle)	
					0 = Low Risk 1 = Medium Risk 2+ = High Risk	

Screening results reported to: L. Friel

Screening completed by: Friel Date: 22.8.10

Conscious Level Chart (only as required for head injury observation)

DATE:		20/8/10										DATE:		
TIME:		13:50										COPY		
COMA SCALE	Eyes Open	Spontaneously	4											
		To speech	3											
		To pain	2											
		None	1											
	Best verbal response	Orientated	5											Endotracheal tube or tracheostomy = T
		Confused	4											
		Inappropriate words	3											
		Incomprehensible sounds	2											
	Best motor response	None	1											Usually record the best arm response
		Obey commands	6											
		Localise pain	5											
		Withdraws to pain	4											
Flexion to pain		3												
Extension to pain	2													
	None	1												

1	2	3	4	5	6	7	8
Pupil Scale (mm)							

PUPILS	right	Size	5										
		Reaction	+										
	left	Size	5										
		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											
		Extension											
No response													

Pain Assessment and Management Guidelines


Pain Score:
 No pain
 Mild = No Pain at Rest
 Slight Pain on Movement
 Moderate = Intermittent Pain at Rest
 Moderate Pain on Movement
 Severe = Continuous Pain at Rest

Nausea Score (0-3):
 0 = No nausea or vomiting
 1 = Nausea only
 2 = Vomiting once
 3 = Vomiting more than once

For Acute and Chronic Pain:
 For mild, moderate or severe pain refer to Pain Management Guidelines Forth Valley Formulary Appendix 27 & 28
 Implement Pain Assessment Chart

For Cancer Related Pain:
 For a mild, moderate or severe pain score, refer to Palliative Guidelines.

Re-order Ref: TF/1013/SS



CHI: 3011795258 30/11/1979 M
 SCRIMSHAW
 GARY
 7 MOSS ROAD
 TILGICOLTRY

Review Date: 2012

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observations See flow chart overleaf and monitor patient

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30
26-29
21-25
9-20
≤8
≥94
92-93
86-91
<86
refer to key

<95
39°
38°
37°
36°
35°
34°
210
≥200
190
180
170
160
150
140
130
120
110
100
90
80
70
60
50
>170
160
150
140
130
120
110
100
90
80
70
60
50
40
30

Alert
Verbal
Pain
Unresponsive
EWS
Blood Glucose
No pain
Mild
Moderate
Severe
Nausea Score 0-3
Initial



Name: CHI: 3011795258 30/11/1979 M
DOB: SCRIMSHAW
Chi No: GARY
Address: 7 MOSS ROAD
TILLCOUNTRY
FK13 6NS

60%)
NIV Patient on NIV system
OTH Other device: _____
(specify which)

COPY

Family Dialogue

Consultant: *Dr. Muir*
 Named Nurse:

Surname: MR GARRY SCRIMSHAW
 Forename:
 Preferred Address: 7 MOSS ROAD,
 TILlicOUNTRY,
 CLACKMANNANSHIRE
 Unit No: FK13 6NS
 DOB:

Date	
<i>20/1/10</i>	<i>20th => EX-WIFE TRULEY, NOK OF</i>
	<i>GARRY - WHO EXPRESSED HER WISHES TO</i>
	<i>BE THE ONLY ONE TO BE UPDATED</i>
	<i>OVER THE PHONE RE. GARRY'S</i>
	<i>CONDITION. ALL INQUIRIES TO BE</i>
	<i>ADVISED TO CONTACT HER FOR AN</i>
	<i>UPDATE.</i>
	<i>J. McNeill Doc.</i>



RADIOLOGY REPORT - Stirling Royal Infirmary

CHI NUMBER: 3011795258 Examination Number: 30701658

Name: Scrimshaw, Gary DOB: 30/11/1979

**Address: 22/4 HILL STREET, TILlicouLTRY, CLACKMANANSHIRE, FK13
6HF --CC: -**

Examination: XR Chest

Examination Date: 20/08/2010 Examination Time: 18:20

Dictating Radiologist: DR PAUL KELLY

Typed by: None

Referring Consultant: MAIR W DR ANAESTHETIST

Referring Department / Location: STIRLING INTENSIVE CARE UNIT

Clinical history: Overdose with reduced coma scale and right IJ line inserted.

Findings: Portable supine film. Mediastinal and pulmonary contours consistent with this. Minor consolidation noted in right cardiophrenic angle. ET tube and right internal jugular line in satisfactory position.

Examination Date: 20/08/2010

Examination: XR Chest

Date Reported: 31/08/2010

Dictating Radiologist / Clinical Specialist By DR PAUL KELLY

Verified by: DR PAUL KELLY on 31/08/2010

20-Aug-2010 18:43:00

GARCIA SCHEINERAW

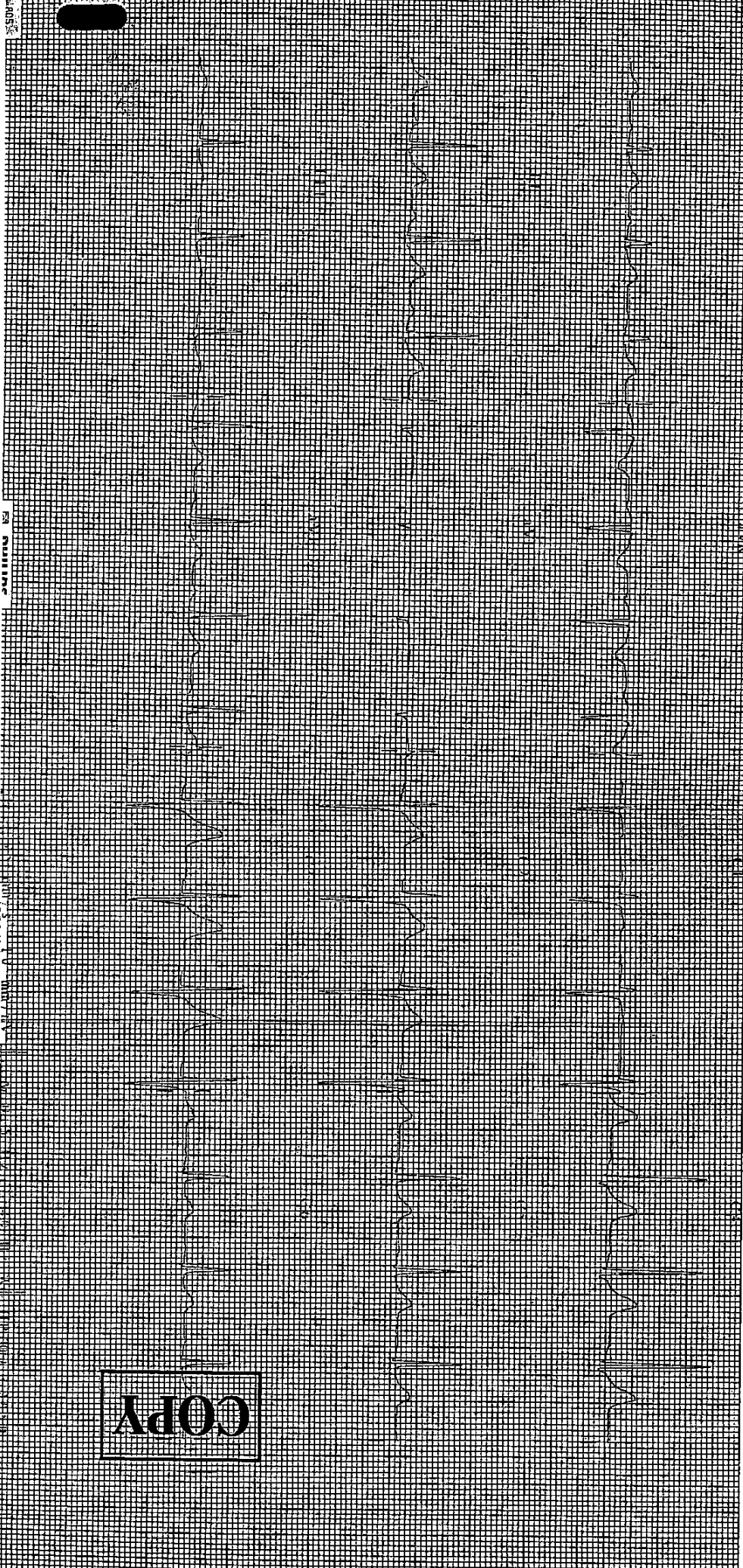
CORONA CARE

Rate 87 AGE NOT ENTERED, ASSUMED TO BE 50 YEARS FOR PURPOSE OF ECG INTERPRETATION
PR 195 NORMAL SINUS RHYTHM, RATE 87
QRS 90
QT 339
QTc 408

--Axis--
P 57
QRS 65
T 46

- NORMAL ECG


Unconfirmed diagnosis.



COPY

Vent. rate 140 bpm
 PR interval 132 ms
 QRS duration 110 ms
 QT/QTc 288/239 ms
 P-R-T axes 59 74 32

Sinus tachycardia
 Cannot rule out Anterior infarct, age... determined
 Abnormal ECG

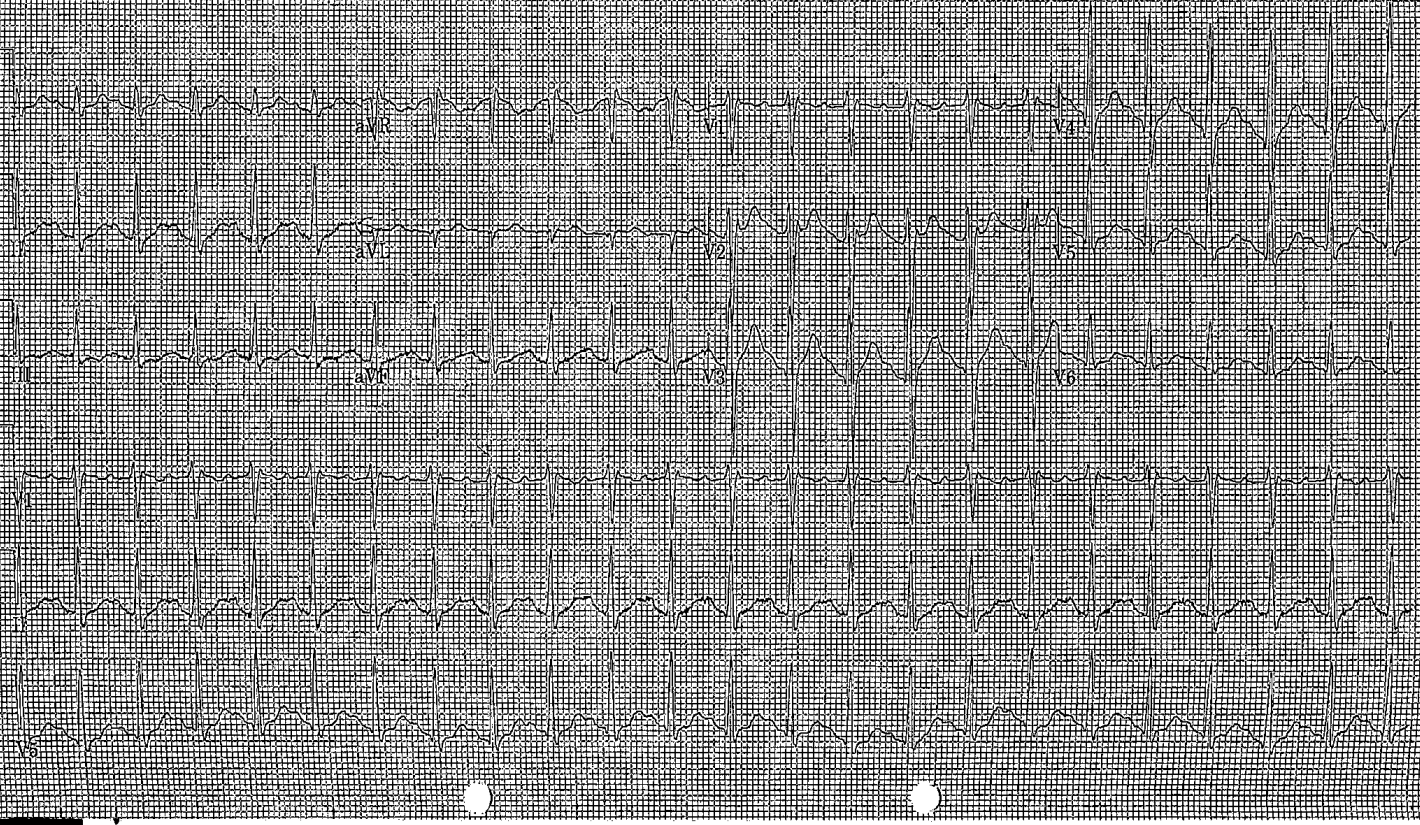

 CHI: 3011795258 30/11/1979 M
 SCRIMSHAW
 GARY
 7 MOSS ROAD
 TILLCOUNTRY
 FK13 6NS



Technical
 68 10

Referred by

Unconfirmed



CLINICAL NOTES



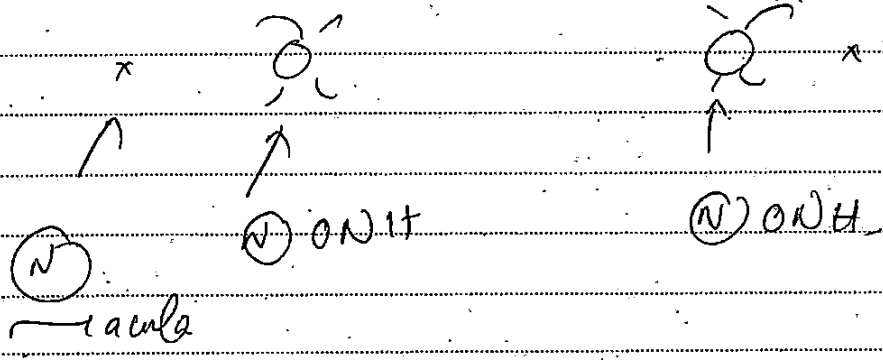
CHI:3011795258
CRN: S237397 30/11/1979
SCRIMSHAW GARRY
Flat 4, 22 Hill Street,
TILLCOUNTRY,
Clackmannanshire
FK13 6HF

abel
ital No. _____
M B. _____
COPY
Ward / Dept. _____

Consultant

Date

30.8.10



Imp. ° Ocular pathology

CT q. EXOCIN x 4/5.

Discharge

R small
ST2.

CLINICAL NOTES

Sui CHI3011795258
 For CRN:S237397 30/11/1979
 SCRIMSHAW GARRY
 Flat 4, 22 Hill Street,
 Ad TILLCOUNTRY,
 Clackmannanshire
 FK13 6HF
 el
 I No.
 M JOLIVE
COPY
 Ward / Dept.

Consultant

AR/JAS

Date

25/8/00

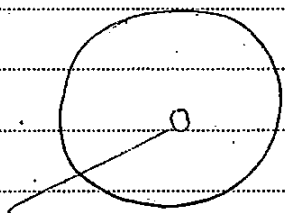
Optician referral with
 acute (R) red painful eye.

Medx Nil Allergy Nil Rxn Nil

VAR B/36 u/a
 6/18 PH

VAR 6/9 u/a
 6/16 PH

Sticky sore R-E 2/7
 Blurred vision 2/7



As ✓

defect
 in Decemets
 memb?

Diffuse PEE

cells + AC

A

11 Conjunctivitis
 4 AC activity?

14

Plan: 4 Conj swabs ← viral
 bacterial
 Chlamydia

Show
 to JAS
 Thank

21 G. Exocin QID R-E 7 See 5/7
 31 Oct Vit corticosteroids QID R-E 8 Pella
 RX7B

Surname SCRIMSHAW Hospital No. 23739

Forenames GARY Sex M

43 EASTCASTLE STREET D. of B. 30/11/1979

Address ALLOA

CLINICAL NOTES

Consultant P.L.C CLINIC

COPY
Ward / Dept.

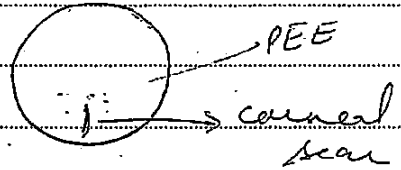
Date

3/11/06
KG

VR, 6/16 EGN VL, 6/16

→ No notes available
H/O. (L) Corneal ulcer perforation (micro) 26/10/06 (TS on call)
followed treated w/ Bandage CL.

Ump G. Exocin Q1D (L-E)



BCL removed
Siedel Negative

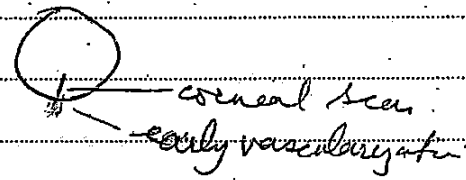
G. Exocin } TID L-E
G. Vitosteen }

See 1/5/12 PCL

10/11/00

RVA G/5 pt

LVA G/5 with G/S



G. Exocin B.P } L-E
Vitosteen B.P }

1/5/12 A

CLINICAL NOTES

Su

Fo

Ad



CHI: 3011795258
CRN: SZ 237397 30/11/1979
SCRIMSHAW GARRY M
43 EASTCASTLE STREET
ALLOA
FK10 1BB

tel

if No.

COPY
Ward / Dept.

Consultant

Date

30/10/06
Lt.

Rv \bar{e} gls = 6/6+3

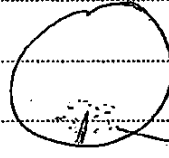
Lv \bar{e} gls + cil = 6/6

Pt was admitted to ward 29 B on Thurs 26/10
+ discharged Fri 27/10/06.

Attended SR1 eye clinic Fri 27/10 and
had soft cil inserted.

(LE) comfortable

RCL in place



epi micropts

Acc quiet

pupil round

Review Friday

3/11/06 - PCC eye

clinic
WGP

CLINICAL NOTES

S
R
At



CHI: 3011795258
GRN: SZ 237397 30/11/1979
SCRIMSHAW GARRY M
43 EASTCASTLE STREET
ALLOA
FK10 1BB

label
al No.

COPY
Status / Dept.

Consultant

Date

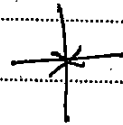
27/10/6
KS

no irritation ++ since insertion of lens -
NOT painful just very ~~++~~ uncomfortable
- worse than prior to insertion -

OLE lens in situ

tears

p v c v m v

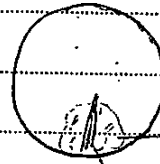


Vu 6/12

CPM 6/9

X ray orbits done
when 1st seen in ALT
on the day of injury

OFF seen



corneal abrasion
corneal laceration

ALT odd all

ALT deep

pupil round

BCL in place
(18mm)

pt no irritation ++

since insertion of BCL

- 9 try smaller BCL

Precis - UV. 8:70:1445:00

p' (initially)

c v

m v

Horneon

Acron x by Sunday

(the)

re Monday procedure

7-40 Clerk (cont'd)

COPY

DHE: None
NKDA

FHE: CVA

SHE: Live w/ wife
unemployed

Tetotal

Smoke < 10/day

PE: Systemically well.

Hands: Warm
No Stigmata

CVS: Pulse 72 (N)
ApeX - undisplaced.
o edema
AS I + II + III

RESP: Expansion }
Percussion } R=L=N
Resonance }

~~AA~~

ABDO: ~~o~~ (SNT
o masses
o fluid
BSV Pulses ✓
o Hepmas.

cyc McCree
293

CLINICAL NOTES

Write - imprint or Attach Label
Surname Scrimshaw Hospital No. 5237397
Forenames Gary Sex M
D. of B. 20/11/79
Address 6 Broompark West
Menstrie
Ward / Dept: **COPY**

Consultant

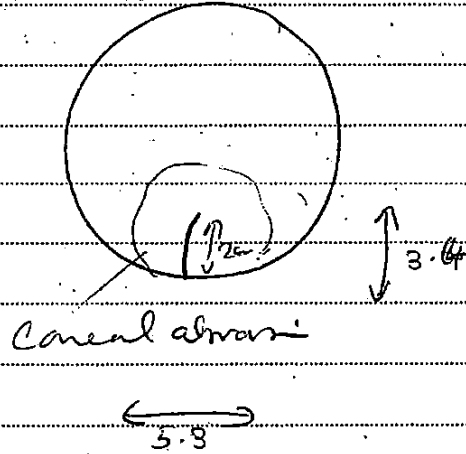
Date

26.10.06

Inj to L eye while removing slabs from wood. Slabs
once went to Eye. - 1wk duration

Admitt

L penetrating corneal wound.
2mm long inf



D/W. Dr T.S.

BCL 18mm.

Exocis 1/2 hourly

Review Tomorrow in clinic.
Dr. Tammar to see. *Jah*

26/10/06
1633

JH. CLERK - IN

PC: AS ABOVE

P/MHx: 1996: Thyroglossal Cyst Removal

1996: Appendicectomy

1996: Repair to cut Thumb tendons

nerves

50st FUSOC

Sho

Atropine H.C. Eucastropine
Phenylephrine Mydrilate
Others

R/L

PMVA -
PMT -

History: prkly Strbs & wood when a pin stuck
at eye while try to remove it
at week ago. give AB drops 4 out
at A/E eye still painful working

Removal Treatment
Dr W Dr - Saboor
admit
BCL 18mm
Exoco-therapy
Review tomorrow

Slit Lamp:

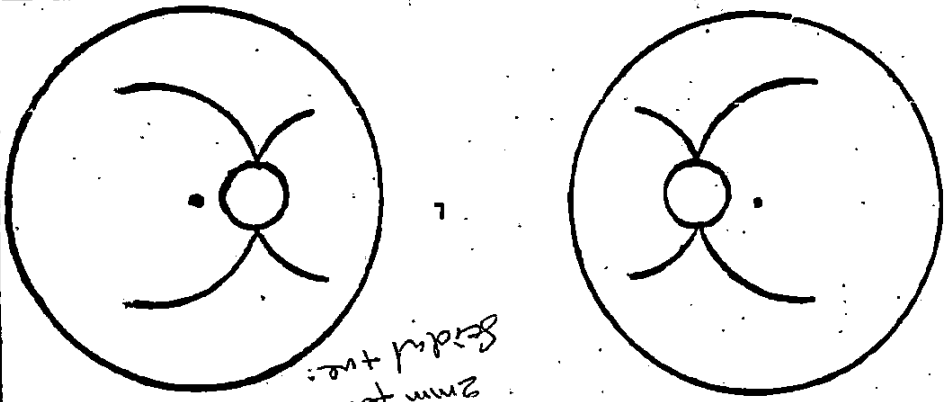
Cornea Lens



Others
K P
Synchia
Angles
Flare
Incorneal
18.50 - 0.3 c/c
Simplex 72 Flare
Wax out
NACL Flare

R

L



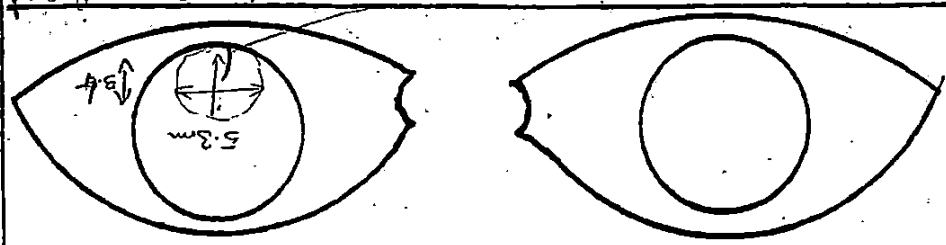
2mm penetrating corneal cut
Scid +ve

Macula
Vessels
Disc
Vitreous
Lens
Iris
Cornea
Tension
AC
Pupils

Ext

Re

Lc



has also not with Lc

Ac quiet

Vision: R/L
with out glasses
with glasses

6/12
6/12
6/12

Diagnosis: ① Penetrating Corneal injury

Allergy:

EYE NOTES

STIRLING ROYAL INFIRMARY
26/10/06
SN 15

D.O.B. 30/11/79

COPY

43 East Castle Street

Gary Scrimshaw
275/154

COPY

ALLOA HEALTH CENTRE

* Dr D S Borland
Dr C B Lamb
Dr F Green
Dr G Riddle

Marshall
ALLOA
FK10 1AB
Telephone No: 01259-216701
Fax No: 01259-724790



RCGP Scotland
2003-2006



3011795258

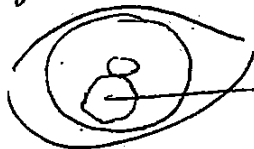
Scrimshaw, Gary
30/11/1979 M
43 Eastcastle Street
ALLOA
55344 Dr Borland

26.10.06

On-call ophthalmologist.

Dear Dr, Many thanks for seeing
this man who was struck in the \odot
eye last Wednesday by a nail. He
was seen in A&E & given chloramphenicol
ointment & ibuprofen drops.

Today his VA is only 6/18,
his eye is watering & uncomfortable.
etc -



Corneal opacity &
staining.
? corneal abscess.

Regards,
Gary

5237397

DR HUDA

THURS 1PM

COPY

ACUTE OPHTHALMOLOGY TELEPHONE REFERRAL INFORMATION FORM
(CIRCLED FORCED CHOICE ENTRIES AS APPROPRIATE)

CALL TAKEN BY: Dr SIN GAVIN AT: SRI / FDRI
 DATE: 26/10/06 TIME: 10.05 am / pm
 FROM: Dr BOLELAND of SRI A&E / FDRI A&E / Ward
 GP Optician
 Other

PATIENT DETAILS
 Surname: SCRIMSHAW C/s no:
 d.o.b. 30.11.79 Forename: CARY
 Address (optional): Phone no: 01259 218581
 Previous Eye Clinic Contact: Yes / No
 If yes, under which Consultant: AC / DH / TS / AS / unknown
 (If yes, fix appointment with relevant Dr / clinic unless urgency dictates otherwise.)

REFERRING DIAGNOSIS / SYMPTOMS AND CURRENT Rx

WED. 18/10/06
 BEEN @ SRI A/E CHLOR GIVEN ? CORNEAL
 VOLTAREL DROPS. ABRASION
 SEEKING GP TODAY EYE PAINFUL ON EXAM ?
 CORNEAL ULCER

APPOINTMENT WITH RECEIVING OPHTHALMOLOGIST

To be seen by: Clinic SHO / Duty SHO / Dr
 To be seen at: SRI Clinic / SRI Ward 21 / FDRI
 Date: 26/10/06 Time: 1PM
 FAX OR SEND TO THE DOCTOR RECEIVING THIS PATIENT

Dr seeing patient at above time/place then enters next stage information:

RECEIVING OPHTHALMOLOGIST'S DIAGNOSIS AND Rx

Patient: Seen, Discharged / Seen, to be reviewed / Admitted / FTS
 Consultant advice sought - by phone / in person / No

PROGRESS NOTES

CHI: 3011795258
SCRIMSHAW
Garry
7 MOSS ROAD,
TILLCOLTRY,
FK13 6NS

30/11/1979

M
ft No
of B

COPY

Date and Time
22/8/10

Psych R/W

Summary 30/10 impulsive overdose in context of social pressures. Denies suicidal intent. Remarkably thankful for treatment. No objective evidence of underlying mental illness. Denies suicidal ideation or thoughts of harm. No immediate psychiatric input required.

Man happy for d/c when medically fit! Will arrange urgent OP for with Dr Collins

Please inform GP on discharge.

Would suggest continued dosing of amitriptyline ~~at this~~ if to continue on discharge.

Happy to r/w if required.

(Will forward copy of full assessment to recall conc in due course)

[Signature]

BOYD CT

1240

ACT RNP

Much improved. Seen by Y as above. Does not wish to continue on amitriptyline. Bloods normal.

Plan: chase today's coag

(U) if normal with Phasagabre

1300

Coag normal. Home

[Signature]

[Signature]
Ref
JOB

Date

Arrived safely from HDU

6:00 - Pt very unsteady on feet, requiring assistance x2 when mobilising

COPY

At high risk of falls.

Spoke to NOK state pt has not eaten since last Friday.

The cream taken at tea-time + 1/2 MINCE POTATOES

Wanting to go out for cigarette.

NOK state unable to access B&B to get pt's belongings. Pt quite anxious re same.

Unsettled overnight + slept very little. Obs. being independently within ward + appeared more steady.

Appears vague + confused.

Didn't appear to know what time of day/night it is

Wanting to get ready for work at 1st floor.

Also looking for his wife in the ward.

21/8/10

3rd floor. Went to bed + appeared to sleep for couple of hours

Dr. Stirling SM

Slip No. 15d

Against Advice

SURNAME (Block Letters)

FIRST NAME (Block Letters)

UNIT NUMBER

This is to certify that I am leaving this Hospital at my own request, at my own risk, and on my own responsibility, and against the advice of the Medical Staff.

Signature

Address

Date 22.8.10

AGAINST ADVICE (Patient)

STB044

CLINICAL NOTES

Write immediately Label
 CHI:3011795258 Hospital No. _____
 CRN: S237397 30/11/1979 x _____
 SCRIMSHAW GARRY M of B. _____
 7 Moss Road,
 TILlicOUNTRY,
 Clackmannanshire
 FK13 6NS

COPY

Consultant

Date

Plan - Stop sedation
 - aim to wean / extubate
 - Paracet infusion continues as prescribed.

WOL

21/8/10

1230

ST3 FLASER

SEVERAL ATTEMPTS MADE TO CONTACT URSULA PSYCH.
 NO ANSWER TO TELEPHONE (MORNING TEAM)
 SWITCHBOARD DON'T HAVE NUMBER FOR SPECIALIST
 PSYCHIATRIC NURSE TEAM.
 NO ANSWER AT USUAL NUMBER CONTAINED IN URSULA
 PSYCH FOLDER.
 PLEASE CAN WYND DODDOR MAKE REFERRAL WITHIN
 PATIENT TRANSFERRED?
 MANY THANKS,

FLASER
 ST3 984

21/8/10
 1315

PATRISA - MED REC CWS

- OD as above Amitriptyline + Para
 - plan as above
 - p. y. li transfer to medical
 ward.

[Signature]

IV Cannula Insertion/Removal Record

Name: Donna RUSSEL Ward: ICU
 Inserted by: Donna RUSSEL Date: 21/8/10
 Size/Colour: 20G (PINK) Batch No: _____
 Insertion Site: ② HAND
 Removed by: _____ Date: _____

CLINICAL NOTES



tal No.

CHI: 3011795258

30/11/1979

M

3

SCRIMSHAW
GARY
7 MOSS ROAD
TILLCOUNTRY
FK13 6NS

COPY

Consultant

Date

20/8/10
1515

- ⑤ WAIT PHARMACOLOGICAL/SALICATE LEVELS
- ⑥ FURNISH BICARBONATE IF BECOMES ACIDOTIC
- ⑦ OXAL FOR ETT
- ⑧ REPEAT ECG IN 1 HOUR
- ⑨ UPDATE NEWS OF KEN

[Signature]
813 984

NOTE: RESPONSE CAN FROM HTK
↳ PARACETAMOL 236

↳ SALICATE UNOBTAINABLE

↳ FOR PARVOLEK

[Signature]
813 984

20/8/10
1730

STB FRASER - LANSFORD

DRAMATIC FALL IN BP TO 50/10, UNRESPONDING
HEART RHYTHM UNCHANGED.

Gang COXSOXINE + long measurement + SEPARATION OFF
BP SOON UP TO 140/70 AGAIN.

Went 10% calcium gluconate plus RINGER SODIUM
(125ml/hr) Sodium Bicarbonate 1.207.

RTS IN SCURO - FRASER

US GUIDED - SURGICAL ATTEMPTS - CLOSE
PROXIMITY TO VASCULAR BUNDLE.

ACCESS AS PROTOCOL

ALL LINES PUSHING/USE.

OXAL - APPROPRIATE PREPARATION

[Signature]
813
984

A = SIZE 8.0 ENT, CLEAR ON SECTION

COPY
BOOKS

B = PSIMU FLO₂ 0.5 15/S SIM PARANISSO

CHEST CLEAR

C = WARM + WICK RECEIVED

TACHYCARDIC - SINUS TACHY QRS 110 QTc 439

RATE ~ 115-140 IBP

UNRECORDED ICG -

HAD ZOOM IN FWD IN THE

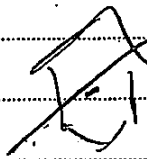
HS L1110

D = GCS 3 PPE PSI

PUPILS SIZE 4, SLUGGISH

BM 4.4

TEMP 35.6



ABDOMEN SOFT
NAD

ECG: SINUS TACHY 140bpm QRS 110 QTc 439

OTHERWISE NIL

UNES: APT LINE 20/8/10 @ 10AM

ICG VENFLOW @ HAND

ICG VENFLOW @ HAND

PLAN ① VENT SIMILE

② WAKE + WEAN AS TABLE

③ ADD CL TO BUDDY

④ MAP > 65 AND V/O > 60ml/hr PLEASE

↳ GEORGINA / BACKGROUND FWD

CLINICAL NOTES

CHI: 3011795258 30/11/1979 M
SCRIMSHAW
GARY
7 MOSS ROAD
TILLCOLTRY
FK13 6NS

11 Level
ospital No.
ex
of B.

COPY
Ward Dept.

Consultant

Date

ICU ADMISSION - ST3 FRASER - PENICILLINIC

20/8/10
1515

300? ADMITTED ATE RESUS @ 1330

NO FIXED ABOVE - LIVES IN BTB/SHELTER

FOUND FACE DOWN ON FLOOR, UNCONSCIOUS, SURROUNDED
BY EMPTY TABLET PACKS.

NOT KNOWN TO ABUSE DRUGS, NO DRUG PALMPHILIA NEAREST.
ONLY PRESCRIBED DRUGS ARE

- ① AMULOPTIMINE
- ② DICLOFENAC
- ③ PARALLETAMOL

} UNKNOWN QUANTITIES
INGESTED

DOES NOT SMELL OF ALCOHOL.

GCS 3 ON ARRIVAL, MAINTAINING OWN AIRWAY

IN @ UPRIGHT POSITION ON C GUGGER AIRWAY + MANDIBULAR MASK

GIVEN SODIUM BICARBONATE SOLN 8.4%, ALTHOUGH NOT
ALLODOL. NO RESPONSE TO 400mg NITROGLY

MODIFIED RSI BY MYSELF FOR AIRWAY PROTECTION.

1mg ALFENTANIL, 50mg PROPOFOL, 100mg SUXAMETHONIUM
GRADE 1 LARYNX, SIZE 8-0 ETT

SECURED -> NO CONTAMINATION. UNCOMPLICATED

HYDROALBUM 50mg + 40mg TO FACILITATE VENTILATION
AND TRANSFER. PROPOFOL 1% @ 10ml/hr.

AFT LUNG SURGED BY DR THORNTON - ABRASIONS

TRANSFER ICU FULL MONITORING UNIDENTIFIED

IV Cannula:

Inserted by:

Time:

Site: *Left + Right*

Size/Colour: *grey/green*

Batch No:

COPY

Pressure Area Assessment / Mobility:

Absolute Risk (Score 2)

Relative Risk (Score 1)

Unconsciousness
Dehydration
Paralysis

Age over 70
Restricted Mobility
Incontinence

Pronounced Emaciation
Redness over bony areas

Trolley

Chair

Mobile

Pain Score: \odot /10

Analgesia Given? Y (N)

Own Meds? Y (N)

Name Band (Y) N

Investigations

FBC
U&Es
LFT
PARACETAMOL

GNJ
CRP
AMY

CLOTTING
G&S
ESR

SALICYLATE

TROP
D DIMER
ABG

URINALYSIS
HCG
CATHETER
ETHANOL

XRAY
CXR
AXR
(ECG)
CULTURES

Troponin 0hr result:

Troponin 12hr due:

*Garry Schimshaw
30/11/19*

Relative/Carer Informed ? YES NO
Present YES NO

AMT 4

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

If score is 3 or less proceed to Delirium screen

		Box 1	
I	Acute Onset and fluctuating course a) Acute change in baselines?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	b) Did the (abnormal) behaviour fluctuate	<input type="checkbox"/> Yes	<input type="checkbox"/> No
II	Inattention e.g. difficulty focusing attention, easily distractible	<input type="checkbox"/> Yes	<input type="checkbox"/> No
		Box 2	
III	Disorganised Thinking (box 2) e.g. disorganised thinking or incoherent speech such as rambling or irrelevant conversation, unclear or illogical flow of ideas	<input type="checkbox"/> Yes	<input type="checkbox"/> No
IV	Alternative Level of Consciousness (box 2) E.g. Alert, drowsy	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If all items in Box 1 are checked and at least one item in Box 2 is checked a diagnosis of delirium is suggested.

DIAGNOSIS

[Empty box for diagnosis]

PATIE



CHI: 3011795258 30/11/1979 M
SCRIMSHAW
GARY
7 MOSS ROAD
TILLCULTRY
FK13 6NS

COPY

TREATMENTS

[Empty box for treatments]

Patient/Legal Guardian Permission to release info for legal purpose including Police
Patient Signature..... Print Name..... Date.....

NURSING DOCUMENTATION

Named Nurse: *Wyle*

Assessment / Intervention

Found unconscious in bedroom ? overdose
- Medication found lying around room amitypteline
and Paracetamol
IV Fluids ✓
Referred medical team
Anaesthetist called ✓

Outstanding Plan:

Admission to ICU

Date: 20/8/10

Clinical Notes

Patient Name:		3011795258
MacIntosh	14 ⁰⁵	SCREWSHAW GAR 30/11/10 DATE: TIME:
Reveals GCS 3		SIGNATURE:
Self ventilating		
SaO ₂ 97%		
HR 122		
Gwa history. likely TCA OD		
I think he needs RSI + ventilator		
Anaesthetics called		
RSI by anesthetic ST3.		
↓ reventful		
→ ITU		

COPY

my

20/8/10

Clinical Notes

3011795258

SCRIMSHAW
GARY

30/11/1979

M

Seen by:

KAVANAGH,

DATE:

TIME:

SIGNATURE

COPY

Found collapsed face down
in room.

Seen c 0900h → Shop →
Back to bedroom n B+B

Someone found him c
called 999.

SAS - ↓ L.O.C. ↓

tobacny quodal amog;

Bm 4.4

Give naloxone foam;

NOT DRUG USER ↓

NO DRUG PARAPHERNALIA

o/a -

A - tobacny quodal.

B - te n = L

C - Bp 120/88

IUA x2 + se - blood -

IUF ✓

D - ECS 3/15

but starting to Sigh

Swallow + some spant

Mums.

Bm - 9.6

Plan - ECE - QRS 118 → hard ✓

Somniel Na bic IV ✓

IV fluids ✓

Might bleed postmortem ✓

ADP - HT 42.6 + rest n

Guidelines Used:

Neuro-ex - tone n / reflexes n

dark on n n

Accident and Emergency Department Stirling Royal Infirmary



3011795258

A&E No. 10047281

COPY

Surname	SCRIMSHAW	Forename	GARY	Title:	
Address:	7 MOSS ROAD	Postcode	FK3 0AJ		
	TILlicOUNTRY CLACKMANNANSHIRE	Telephone:			
Date of Birth:	30.11.79	Sex:	M	Age:	30 yrs

GP Name:	KOLLE ANDREAS				
Address:	TILlicOUNTRY MEDICA...	Postcode	FK13 6AG		
	PARK STREET TILlicOUNTRY	Telephone:	01259 750531		
			07935 630569		

Next of Kin Relationship:	TRACEY SCRIMSHAW				
Address:	FLAT 4, 22 HILL STREET	Postcode	FK13 6HF		
	TILlicOUNTRY CLACKMANNANSHIRE	Telephone:	XXXXXXXXXX		
Manual CHI Entry:			0754 696 7107		

Date of Attendance: 20.08.10 13:37
 Date of Incident:
 Presenting Complaint: UNCONCIOUS

Triage	Tetanus Cover:
	Allergies:
P=	BP= / RR= Sat= BM=
PF=	GCS=E: M: V: Total:

Drugs Prescribed

Date	Drug	Dose	Route	Signature	Given By	Time

OPHTHALMOLOGY DEPARTMENT

Consultants: Dr J A Scott (Lead Clinician)
Dr J D Huggan
Dr T Saboor
Dr J Gillen

Stirling Royal Infirmary
Livilands
Stirling
FK8 2AU
Tel: (01786) 434000
www.show.scot.nhs.uk/nhsfv

COPY

AR/JP/ S237397
CHI No: 3011795258

24th November 2006

Dr Borland
Health Centre
Marshall
Alloa
FK10 1AB

Dear Dr Borland

Gary Scrimshaw (30.11.79) 43 East Castle Street Alloa

This patient had left corneal micro-perforation about 4 weeks ago. He has attended the clinic several times since then. He failed to attend today and also on the 17th November.

When last seen there was a small corneal scar affecting his left eye. Visual acuity was 6/6 and he was still on Exocin drops and Viscotears gel drops twice a day to the left eye. Presumably his symptoms have now resolved. I have therefore discharged him. No further treatment is required. If there is a further problem please refer him again.

Yours sincerely

A Ramsay
Locum Staff Grade in Ophthalmology

NHS Forth Valley

Carseview House
Castle Business Park
Stirling
FK9 4SW



Telephone: 01324 566292
Fax:

Private and Confidential

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

Date: 29 April 2026
Your Ref: 100106
Our Ref: GDP/0021239

Enquiries to: Legal Admin Team
Extension:
Direct Line: 01324 566292

Dear Sir/Madam

Re: Gary Scrimshaw

With reference to your recent access request please find enclosed copy health records as requested.

Please note that records held by Forth Valley Royal Hospital will include records for Falkirk Community Hospital and Stirling Health & Care Village.

If we can be of any further assistance then please do not hesitate to contact us.

Yours Sincerely

A handwritten signature in black ink, appearing to be 'MMA' or similar, written over a horizontal line.

Legal Admin Team

E-mail: fv.healthrecs-legal@nhs.scot

NHS Forth Valley
Headquarters: Carseview House, Castle Business Park, Stirling, FK9 4SW

nhsforthvalley.com [/nhsforthvalley](https://www.facebook.com/nhsforthvalley)
 [@nhsforthvalley](https://twitter.com/nhsforthvalley) [@nhsforthvalley](https://www.instagram.com/nhsforthvalley)



Date of attendance: 20/05/2024 22:04
 Presenting complaint: chest pain (Sas.wr)

Surname: Scrimshaw	Forename: Gary	Title: Mr
Address: 40 Johnston Crescent	Postcode: FK13 6PZ	CHI: 3011795258
Tillicoultry Clackmannanshire		
Telephone: 07340830479		
Date of Birth: 30/11/1979	Sex: Male	Age: 44 Years
GP Name: G Campbell		
Address: 25544/1	Telephone: 01259 750531	
Tillicoultry Medical Practice Park Street Tillicoultry Tillicoultry FK13 6AG		
Next of Kin		
Name: Tracey Scrimshaw		
Relationship: Wife	Postcode: FK13 6PZ	
Address: 40 Johnston Crescent	Telephone: 07423556817	
Tillicoultry Clackmannanshire		
Triage Information		
chest pain R sided chest pain, stabbing in nature, non radiating, clammy, sweaty - denies pain at triage, no cardiac hx recent problem		
Observations		
P= 63	BP= 124/67	RR= 17
Peak Flow=	GCS=	Sat= 97
		BM=
		Temp= 36.6
		News= 0

Emergency Department / Pre-Hospital Drugs				Allergies			
Date	Drug	Dose	Route	Signature	Given by	Time	

DNW

PVC INSERTION BUNDLE AND REMOVAL RECORD

PLEASE COMPLETE ALL BOXES

The patient's skin is decontaminated and allowed to dry YES / NO
 Hand hygiene & gloves donned prior to insertion YES / NO
 Aseptic Non Touch Technique is used to insert PVC YES / NO
 If not possible, use either STERILE GLOVES or MINI CHLORAPREP
 Sterile dressing & sticker (date & time) applied after insertion YES / NO

GARY SCRIMSHAW
 PATIENT LABEL
 300795258

Why is PVC clinically indicated for patient?: (please tick)

IV Fluids: Blood-Transfusion
 IV Drugs Diagnostics
 Predicted clinical need

Colour: _____
 Insertion Site: _____
 Ward/Department: _____
 Inserted by: _____
 Date & Time: _____
 Removed: YES / NO

INVESTIGATIONS

Bloods Required:

FBC U&E GLU LFT CRP AMY CLOTTING G&S ESR PARACETAMOL
 TROP D-DIMER CULTURES VBG* ABG* (*attach to notes) URINALYSIS HCG ECG
 Others: _____
 BLOODS TAKEN? YES / NO TIME TAKEN 20:00
 SIGN: *[Signature]*
 PRINT: *[Signature]*

Preliminary Pressure Ulcer Risk Assessment (PPURA):

Mobility: Person is fully mobile without equipment/assistance Points to Consider
 Contenance: Person is fully continent * People who are overweight may not be well nourished
 Nutrition: Person appears well nourished and able to eat and drink * Use of repositioning mattress or pressure relieving heel protectors.
 Skin: Skin to pressure points satisfactory/intact

Record your answer in the grid below Y = Yes or N = No
 If the answer is NO to any assessments undertake a BRADEN and consider any other assessment

DATE	TIME	MOBILITY	CONTINENCE	NUTRITION	SKIN INSPECTED	SKIN INTACT	BRADEN COMPLETED	SIGNATURE
SKIN DESCRIPTION: i.e. REDNESS, SKIN BROKEN, BLISTER / ULCER						ACTION TAKEN		

4-AT

ALERTNESS (assess for drowsiness or agitation, if asleep attempt to rouse)		Tick
Normal	0	
Mild sleepiness (easily roused <10 seconds)	0	
Clearly abnormal	4	
AMT4 (age, date of birth, place, current year)		Tick
No mistakes	0	
1 mistake	1	
2 or more mistakes	2	
ATTENTION (ask for months of the year backwards)		Tick
Achieves 7 or more correctly	0	
Starts but scores less than 7/Refuses to start	1	
Untestable	2	
ACUTE CHANGE OR FLUCTUATION (significant change incl. evidence of psychotic symptoms)		Tick
No	0	
Yes	4	
Total score (score of 4 or more indicates likely delirium - initiate TIME bundle)		

FALLS TRIGGER TOOL (Complete only if 65 years or over)

2 or more falls in the last 6 months? YES / NO Tries to walk alone and is unsteady? YES / NO
 Fall since admission to department? YES / NO Patient/relatives anxious about falls YES / NO
 Admitted to department with fall? YES / NO 4AT more than 4/evidence of confusion YES / NO
 COMPLETED BY _____

If you have answered yes to 2 or more questions,
 • For patients being admitted please document recommendation that a full care bundle is required to be completed.
 • Please add FALLS RISK IDENTIFIER to Trakcare (EPR -> Patient Alerts -> New -> Ward Signifiers -> Falls risk).

PATIENT LABEL

CLINICAL NOTES

Lined area for clinical notes.

Near Patient Testing Results		
Troponin.....Initials.....	Blood Gases	Fast
Time of Trop.....	Arterial/venous (circle)	Free fluid identified:
D-dimer.....	Time taken	Yes/No (circle)
Urine dipstick	FiO2	AAA
Leucs	pH	Aorta clearly seen
Nitrite	pCO2	Yes/No (circle)
Protein	PO2	Measured diameter.....
Blood	BE	Protetanus
Ketones	Lactate	Immune/Not immune (circle)
Glucose	Urine Pregnancy Test	
	HCG positive/negative (circle)	

Patient/Legal Guardian Permission to release info for legal purpose including Police Yes / No

Patient Signature..... Print Name..... Date.....

0720264

Incident Number: CR01041114

Patient Information

GARY SCRIMSHAW

Age/Gender: 44 years 5 months 21 days Old Male

Address: 40 JONSTON CR.
TULLICOUNTRY

DOB: 30/11/1979

CHI: 3011795258

Ethnicity: White Scottish

file 3 6P2

Date: 20/05/2024

Incident Number: CR010941114

Incident Type: EMG

Incident Location: NEW BREWERY
KELLIEBANK ALLOA,
FK10 1NU



Presenting Complaint

AS144YOM CHEST PAIN

Additional Comments

O/a alert and orientated gcs15. At work. hpc - since 1400 has been having intermittent chest pain at rest. Episodes lasting 10-15 mins each time, started at rest, radiates to right arm and down to fingers. Has been feeling nauseated and clammy. Also feels SOB during these episodes. Worsening whilst at work tonight called ambulance then. o/e - obs as charted. Chest clear, 12 lead ecg sinus rhythm with what appears to be an rsr pattern on v1 and v2. given aspirin and gtn. Pain score was 6/10 with sas, was worse before sas arrival. After gtn pain reduced to a 1/10. unknown if family hx of heart problems as grown up through care system. Shx - lives with wife, smoker, no alcohol intake. transported to frvh for assessment. nok = tracey - 07423556817.

PATIENT ASSESSMENT

ACVPU Alert <C> No

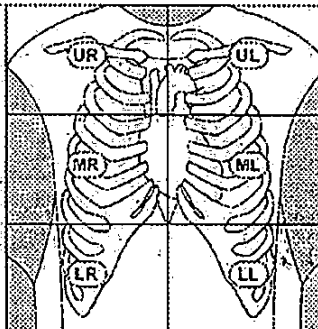
A Clear

B Breathing Adequately Yes Respiratory Rate 20 SPO2 97

Oxygen Given No

Normal Percussion, Normal Breath Sounds, Normal Air Entry

UR



Normal Percussion, Normal Breath Sounds, Normal Air Entry

UL

Normal Percussion, Normal Breath Sounds, Normal Air Entry

MR

Normal Percussion, Normal Breath Sounds, Normal Air Entry

ML

Normal Percussion, Normal Breath Sounds, Normal Air Entry

LR

Normal Percussion, Normal Breath Sounds, Normal Air Entry

LL

C Pulse Rate 85 BP 146/84 Cap Refill <=2 Secs ECG Rhythm Sinus Rhythm

Rhythm Reg Right Arm Peripheral Central/Peripheral ECG

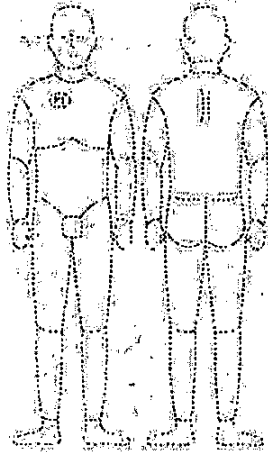
D GCS 15 Eyes Spontaneously (4) Voice Orientated (5) Motor Obeys Commands (6) PEARL

E

[REDACTED]

02220

Indice Number: CH033114



Pain

ID	Body Part	Pain Scale
P1	Chest	6

Observations

Time	P	RR	BP	SpO2	CR	GCS	ACVPU	ETCO2	T	BM	ECG	P(L)	P(R)	PEF	CrowID
21:38	72	18	120/64	97	<=2s	15	Alert								E0000196
21:13	85	20	146/84	97	<=2 Secs	15	Alert		36.8	8	Sinus Rhythm				E9886581

NEWS2

Time	RR	SpO2 Scale 1	SpO2 Scale 2	Air/O2	BP	P	ACVPU	T	Total
21:13	20 (0)	97 (0)		0	146 (0)	85 (0)	Alert (0)	36.8 (0)	0

Drugs

Time	Drug	Dosage	Units	Route	Drug Expiry Date	Pain Before	Pain After	CrowID
21:30	Aspirin	300	mg	OR	06/2025			E0000196
21:32	GTN	600	mcg	SL	06/2026	6	3	E0000196

HISTORY

AMPLE

Allergies	None
Medication	SEE ECS
Past Medical History	SHERMANS DISEASE (BACK CURVATURE, BACK INJURY)
Last Eaten	>4 Hours Ago
Events Prior	CHEST PAIN INTERMITTENT SINCE 1400, WORSENING

Social History

Lives alone	No	Living With	WIFE	Patient Occupation	FACTORY WORKER
Patients General Appearance	Normal				
Living Arrangement	Dependents				
Patient Mobility	Fully Mobile				
Patient Communication	No Help Required				
Patient Clinical Risk Factors	Smoker				
Patient Environmental Risk Factors	None Identified				

020224 Incident Number: CR01031194

Site	RIGHT SIDE	Onset	1400 ONWARDS
Character	TIGHT STABBING, Intermitent, Worsening	Radiates	Yes, RIGHT ARM TO FINGER TIPS
Associated Symptoms	CLAMMY, Nausea	Timing	LASTS 10-15 MINS EACH EPISODE
Exacerbating Or Relieving Symptoms	GTN HELPED.	Severity	6/10

Safeguarding

Safeguarding Assessment Adult: >= 16

MEDICAL

ACS

Associated Symptoms Breathlessness

CLOSE RECORD

Treatment On Scene Non-Emergency

Conveyance

Transport To Hospital Normal driving Pre-Alert No

INCIDENT LOG

Time Call Received	20:48	Allocated	20:49	Mobile	20:49
First Resource On Scene		Crew On Scene	21:04	Crew Left Scene	21:32
Crew At Hosp	21:51	Receiving Hospital	FORTH VALLEY ROYAL HOSPITAL	Clear Time	
Crew ID	E0000196	Crew Grade	Paramedic	Driver	YES
	E9886581		Paramedic		NO

Faint, illegible text, possibly a header or introductory paragraph.

SECRET

SECRET

Main body of faint, illegible text, possibly a list or detailed report.

Emergency Discharge Letter (Authorised)

G Campbell
Tillicoultry Medical Practice
Park Street
Tillicoultry
Tillicoultry
FK13 6AG

FVRH Emergency Department
Stirling Road
Larbert
Larbert
Stirlingshire
FK5 4WR

Dept. Contact Details:

CHI Barcode:



3011795258

Date of Completion: 21-May-2024

GP Practice

GP Name:	G Campbell	GP GMC:	7277373
GP Practice Address:		GP Practice Code:	7277373/25544
		GP Clinic Code:	25544
		GP Telephone:	

Patient Demographics

Patient Name:	SCRIMSHAW, Gary	Date Of Birth:	30-Nov-1979
Patient Address:	40 Johnston Crescent Tillicoultry Clackmannanshire FK13 6PZ	Gender:	Male
Telephone No:	07340830479	CHI No:	3011795258

Admission Details

Patient Location:	FVRH Emergency Department	Admission Date:	20-May-2024
Admission Care Provider:	Dr Ainsley Heyworth	Admission Time:	22:04
Source Of Admission:	999 Emergency Services		

Presenting Complaint

chest pain (Sas wr)

Diagnosis

Diagnosis	Site	Laterality
ED diagnosis - Left before clinical assessment		

Procedures

No Procedure Results

Medications

Nil records exist.

Discharge Details

Discharge Type:	Admitted	Discharge Date:	21-May-2024
Discharge Destination:	Admission to same NHS healthcare provider / hospital - Medical Ward	Discharge Time:	03:01
Referred To:			

Notes for GP

Person completing record

Authorised by

Name:

Designation or role:

Specialty:

Date completed: 21-May-2024

Clinically completed by

Name:

Designation or role:

Specialty:

Distribution List

Recipient Name

G Campbell

Recipient Type

GP

Recipient Organisation

Tillicoultry Medical Practice

Immediate Discharge Letter (Authorised)

G Campbell
Tillicoultry Medical Practice
Park Street
Tillicoultry
Tillicoultry
FK13 6AG

Acute Medicine
Stirling Road
Larbert
Larbert
Stirlingshire
FK5 4WR

Dept. Contact Details:

CHI Barcode:



Date of Completion: 21-May-2024

Patient Demographics			
Patient Name:	SCRIMSHAW, Gary	Date Of Birth:	30-Nov-1979
Patient Address:	40 Johnston Crescent Tillicoultry Clackmannanshire FK13 6PZ	Gender:	Male
Telephone No:	07340830479	CHI No:	3011795258

GP Practice			
GP Name:	G Campbell	GP GMC:	7277373
GP Practice Address:		GP Practice Code:	7277373/25544
		GP Clinic Code:	25544
		GP Telephone:	

Admission Details			
Patient Location:	Acute Medicine	Admission Care Provider:	Dr Daniel Beckett
Admission Date:	21-May-2024	Admission Time:	15:11
Admission Method:	Emergency Admission, no additional detail added	Ward:	FVRH UCC SDEC
Source Of Admission:	GP Non Obstetrics - other Provider.		

Discharge Details			
Discharge Specialty:	Acute Medicine	Discharge Care Provider:	Dr Daniel Beckett
Discharge Date:	21-May-2024	Ward:	FVRH UCC SDEC
Discharge Time:	16:49	Discharge Destination:	Private Residence - no additional detail added
Discharge Method:	Regular discharge, no additional detail added		

Clinical Summary including History	
Dear Dr,	
Gary attended RACU with 1/52 history of chest tightness and SOB intermittent in nature. Non exertional. Describes episode yesterday severe with associated clamminess with palpitations whilst at work. No cough/feverish symptoms/nausea.	
Obs/ BP:131/82 hr 54 rr 16 O2 98% ra. temp 36.3C	
OE/ pulse reg HS I+II+O chest clear	
ECG nsr	
CXR nad	
Bloods checked in ED 20/5 no change in presentation normal FBC, UES, LFTs, troponin. D dimer checked today normal.	

Imp/ MSK injury / stress

Plan/
Home with worsening symptom

Should you require any further information please contact RACU.

Kind regards, Dr. Catriona Parker, GPWSI acute medicine

Safety Alerts

Nil records exist

Allergy/Intolerance -

Allergy records are as recorded at time and date of printing

Nil records exist

Medications -**Drug Information:**

Drug	Dose	Route	Frequency	GP to Continue	POD	Days Supply
------	------	-------	-----------	----------------	-----	-------------

Nil records exist

Drug Notes:

Drug	Drug Notes
------	------------

Nil records exist

Additional Medicine Information:

Medicines discontinued during admission (Medicines that patient was recorded as admitted on only)

Drug	Discontinued Reason
------	---------------------

Nil records exist

GP Communications:**Outstanding Results -****Responsibility of Hospital:**

Nil records exist

Person completing record**Authorised by:**

Name:

Designation or role:

Specialty:

Date completed: 21-May-2024

Clinically completed by:

Name:

Designation or role:

Specialty:

Distribution List

Recipient Name

G Campbell

Recipient Type

GP

Recipient Organisation

Tillcoultry Medical Practice

Emergency Discharge Letter (Authorised)

AE Kolle
Tillicoultry Medical Practice
Park Street
Tillicoultry
Tillicoultry
FK13 6AG

FVRH Emergency Department
Stirling Road
Larbert
Larbert
Stirlingshire
FK5 4WR

Dept. Contact Details:

CHI Barcode:



3011795258

Date of Completion: 27-May-2021

GP Practice			
GP Name:	AE Kolle	GP GMC:	4269506
GP Practice Address:	Tillicoultry Medical Practice Park Street Tillicoultry Tillicoultry FK13 6AG	GP Practice Code:	4269506/25544
		GP Clinic Code:	25544/1
		GP Telephone:	01259 750531

Patient Demographics			
Patient Name:	SCRIMSHAW, Gary	Date Of Birth:	30-Nov-1979
Patient Address:	40 Johnston Crescent Tillicoultry Clackmannanshire FK13 6PZ	Gender:	Male
		CHI No:	3011795258
Telephone No:	07340830479		

Admission Details			
Patient Location:	FVRH Emergency Department	Admission Date:	26-May-2021
Admission Care Provider:	Dr Laura Muir	Admission Time:	12:07
Source Of Admission:	Self referral		

Presenting Complaint	
r knee inj	

Diagnosis		
Diagnosis	Site	Laterality
ED diagnosis - Redirection - ED nurse redirection (as per policy)		

Procedures	
No Procedure Results	

Medications	
Nil records exist	

Discharge Details			
Discharge Type:	With follow up	Discharge Date:	26-May-2021
Discharge Destination:	Private Residence - Usual place of residence	Discharge Time:	12:24

Referred To:

Notes for GP

referred to UCC for L knee inj, app time 1230.

Person completing record

Name:	Dr Emma Elliott	Specialty:	
Designation or role:	Consultant	Date completed:	27-May-2021

Distribution List

Recipient Name	Recipient Type	Recipient Organisation
AE Kelle	GP	Tillicoultry Medical Practice

Emergency Discharge Letter (Authorised)

AE Kelle
Tillicoultry Medical Practice
Park Street
Tillicoultry
Tillicoultry
FK13 6AG

FVRH Urgent Care Centre
Stirling Road
Larbert
Larbert
Stirlingshire
FK5 4WR

Dept. Contact Details:

CHI Barcode:



3011795258

Date of Completion: 26-May-2021

GP Practice			
GP Name:	AE Kelle	GP GMC:	4269506
GP Practice Address:	Tillicoultry Medical Practice Park Street Tillicoultry Tillicoultry FK13 6AG	GP Practice Code:	4269506/25544
		GP Clinic Code:	25544/1
		GP Telephone:	01259 750531

Patient Demographics			
Patient Name:	SCRIMSHAW, Gary	Date Of Birth:	30-Nov-1979
Patient Address:	40 Johnston Crescent Tillicoultry Clackmannanshire FK13 6PZ	Gender:	Male
		CHI No:	3011795258
Telephone No:	07340830479		

Admission Details			
Patient Location:	FVRH Urgent Care Centre	Admission Date:	26-May-2021
Admission Care Provider:	Urgent Care Centre Clinician	Admission Time:	12:27
Source Of Admission:	Self referral		

Presenting Complaint:
Right leg inj appt 12:30

Diagnosis		
Diagnosis	Site	Laterality
ED injury - soft tissue - Other Soft tissue injury		

Procedures
No Procedure Results

Medications
Nil records exist

Discharge Details			
Discharge Type:	With no follow up	Discharge Date:	26-May-2021
Discharge Destination:	Private Residence - Usual place of residence	Discharge Time:	13:27

Referred To:

Notes for GP

- 1. P/C -Right knee injury
Brought in on wheelchair. Attends with wife. Normally independant. Works in Brewery
- 2. H/P/C -Standing on equipment at work, part of machinery gave way, foot slipped and right lower leg slipped between gap in metal machinery suspending pt by right knee about 11am today. Ongoing knee pain and abrasions to knee. Applied ice at time
- 3. Relevant PMH/Meds - Back pain. Meds - Amytriptyline, Co-codamol 30/500 NKDA
- 4. O/E -Superficial wound to medial aspect right knee, 2x superficial/partial thickness abrasions/wounds to lateral aspect right knee. Woundbed visible, no FB/underlying structures, no discharge, no signs of infection. No NV deficit, CRT <2secs. No obvious swelling or bruising to knee. No deformity. No effusion. No popliteal swelling. Tender over medial aspect right knee. No bone tenderness foot, ankle, fibia, tibia, fibular head, tibial tuberosity, tibial plateaux, lateral condyls, patella, femur. FROM of ankle no pain. Able to straight leg raise. Able to fully extend - but with pain. Active flexion 165 degrees, L=R=N, but with pain. ACL, PCL, LCL, MCL intact, no laxity or increased pain on resisted testing. Pt able to independently mobilise around department.
- 5. Ix -
- 6. Dx -Soft tissue injury right knee
- 7. Tx -Wounds cleaned and dressed with siloflex and mepore dressings. Wound and dressing advice given. Given knee injury advice sheet. Advised mobilise knee ++ as able. Advised regular analgesia. Advised to monitor for signs of infection.
- 8. Plan -Discharge. If signs of infection or ongoing concerns return G.P or NHS 24
- 9. GP note -

Person completing record

Name:	Ms Cafriona Quirk	Specialty:	
Designation or role:	Emergency Nurse Practitioner	Date completed:	26-May-2021

Distribution List

Recipient Name	Recipient Type	Recipient Organisation
AE Kelle	GP	Tillicoultry Medical Practice

Dr Andreas Kolle
Tillicoultry Medical Practice
Park Street
Tillicoultry
FK13 6AG

Date Dictated 16 November 2020
Date Typed 16 November 2020

Our Ref XA/3011795258
CHI 3011795258

Discharge Summary

Dear Dr Kollé

Gary Scrimshaw 30/11/1979
40 Johnston Crescent Tillicoultry Clackmannanshire FK13 6PZ

Diagnosis: Right shoulder pain after falling from road bike

Outcome

<input type="checkbox"/>	Much better / Problem resolved
<input type="checkbox"/>	Improved
<input type="checkbox"/>	No change
<input type="checkbox"/>	Worse
<input checked="" type="checkbox"/>	Patient did not complete course of treatment
<input type="checkbox"/>	Patient did not attend initial appointment
<input type="checkbox"/>	Patient failed to respond to offer of appointment letter
<input type="checkbox"/>	Patient declined initial appointment

Additional Comments:

Number of sessions: 1 (telephone)



Pain started after a bike fall on 30/09/2020. Patient reported decreased movement due to pain. Attended A&E - X-ray (no fracture, but showed tendon calcification). I offered him a face to face consultation. Unfortunately, he did not attend this appointment and has not contacted the department since. Therefore, outcome is unknown.

Yours sincerely

(Electronically checked by Xabier Ariztegieta)

Chair: Jamie McGusker
Chief Executive: Cathie Cowan

Forth Valley NHS Board is the common name for Forth Valley Health Board
Registered Office: Carseview House, Castle Business Park, Stirling, FK9 4SN

www.nhsforthvalley.com  [Facebook.com/nhsforthvalley](https://www.facebook.com/nhsforthvalley)  [@nhsforthvalley](mailto:nhsforthvalley@nhs.uk)



INVESTORS
IN PEOPLE

Gold
Until 2021

Xabier Ariztegieta
HCPC Registered Physiotherapist

For NHS Forth Valley physiotherapy appointments and queries contact the AHP MSK Hub on 01324
673890 or FV-UHB:AHPMSKHub@nhs.net

Emergency Discharge Letter (Authorised)

AE Kolle
Tillicoultry Medical Practice
Park Street
Tillicoultry
Tillicoultry
FK13 6AG

SCH Minor Injuries
Livlands Gate
Stirling
Stirling
Stirlingshire
FK8 2AU

Dept. Contact Details:

CHI Barcode:



3011795258

Date of Completion: 02-Oct-2020

GP Practice			
GP Name:	AE Kolle	GP GMC:	4269506
GP Practice Address:	Tillicoultry Medical Practice Park Street Tillicoultry Tillicoultry FK13 6AG	GP Practice Code:	4269506/25544
		GP Clinic Code:	25544/1
		GP Telephone:	01259 750531

Patient Demographics			
Patient Name:	SCRIMSHAW, Gary	Date Of Birth:	30-Nov-1979
Patient Address:	40 Johnston Crescent Tillicoultry Clackmannanshire FK13 6PZ	Gender:	Male
		CHI No:	3011795258
Telephone No:	07340830479		

Admission Details			
Patient Location:	SCH Minor Injuries	Admission Date:	02-Oct-2020
Admission Care Provider:	Dr Joanne Mitchell	Admission Time:	10:14
Source Of Admission:	Not Known		

Presenting Complaint	
r-shoulder inj	

Diagnosis		
Diagnosis	Site	Laterality
Calcific Tendinitis of Shoulder		

Procedures	
No Procedure Results	

Medications	
Nil records exist	

Discharge Details			
Discharge Type:	With referral	Discharge Date:	02-Oct-2020
Discharge Destination:	Private Residence - Usual place of residence	Discharge Time:	13:17

Referred To: Physiotherapy

Notes for GP

PC: Right shoulder injury.
HPC: Fall from bike hitting bollard. Pain in right shoulder since. Already has pain in shoulder since previous fall. No head injury.
PMH: Nil
Symptoms: Pain anterior right shoulder. No altered neuro
OE: No obvious swelling, erythema, bruising, deformity.

Neck NAD

Shoulder- flex 90, Abd 90 LR full. Pain with hand behind back.

MP 5/5 with pain on abd and LR.

Drop arm -ve

NV intact.

X-RAY: No # seen. RC calcification.

Treatment: Collar and cuff. 1 - 2 days. Shoulder advice sheet.

Plan: Physio

GP Action: Nil

Person completing record

Name:	Specialty:
Designation or role:	Date completed: 02-Oct-2020

Distribution List

Recipient Name	Recipient Type	Recipient Organisation
AE Kelle	GP	Tillicoultry Medical Practice

Hospital use only	Clinic	Day Date	Time	Hospital No.
-------------------	--------	----------	------	--------------

Date Referral Submitted
(This date is fixed at hospital end):
08-Sep-2020

REFERRAL LETTER
MEDICAL IN
CONFIDENCE

3011795258

CHI No: 3011795258

101021629631U

Unique Care Pathway Number: 101021629631U

REFERRAL TO	
Physiotherapy - Musculoskeletal R5V5 FY Physio - Musculoskeletal	? — Consultant / receiving practitioner and/or specialty clinic
Forth Valley Royal Hospital Stirling Road Larbert FK5 4WR	? — Hospital and hospital address Hospital location code: V217H
Urgency of Referral Routine Physiotherapy - General Musculoskeletal Referral??	
Administrative Information Patient has special requirements: No Ethnic Origin: (White) British ?	

PATIENT DETAILS	
Surname Scrimshaw Forename(s) Gary Title - Sex Male Previous Surname - Date of birth 30-Nov-1979 CHI no. 3011795258	Patient's address 40 Johnstone Crescent Tillicoultry FK13 6PZ Contact number(s) Voice: 07340830479 E-mail: garyscrimshaw@gmail.com

REFERRING PRACTITIONER DETAILS	
Name: Dr. Andreas Kolie (GMC: 4269506) Practice: Tillicoultry Medical Practice (25544) Phone: Voice: 01259 750531	Practice address: Park Street Tillicoultry FK13 6AG

CLINICAL INFORMATION**History of presenting complaint / examination findings / investigation results****Presenting Complaint**

Description: Assessment.

Comment: This 40 year old gentleman works in a factory filling bottles. He has a 4 month history of a painful right shoulder. He points to the regimental badge area on the top of the shoulder, at the back as well. He has limited arc, being able to elevate the arm sideways up to 80 degrees and is unable really to move to a position if he wanted to pour out bottle.

I would be grateful for your further assessment and advice. He asked for some exercises to do and I gave him a link to NHS Inform - musculo skeletal zone to start with. He is already on Co-codamol and Amitriptyline for back problems and I have added some Naproxen today.

Thank you very much.

Kind regards.

Dr. A E Kelle
Typed 08.09.2020 - FG

Examinations and Investigations

Murmur present: Not Recorded -
Is a 12 lead ECG: Not done -
Recent CXR: Not done -
FBC: Not Recorded -
Urea and Electrolytes: Not Recorded -
LFT: Not Recorded -
TFT: Not Recorded -
Lipid Profile: Not Recorded -
Glucose: Not Recorded -
Known risks: None -

Patient Measurements

<u>Diastolic</u>	<u>Systolic</u>	<u>Height</u>	<u>Weight</u>	<u>BMI</u>	<u>Date Recorded</u>
109	60				17-Aug-2010

Reason for referral

Care type requested: Out Patient
Expected outcome: Investigate

Medical history**Pre-existing Conditions (High Priority)**

<u>Description</u>	<u>?? Laterality</u>	<u>?? Modifier</u>	<u>?? Extension</u>	<u>?? Date Started</u>	<u>??</u>
[X]Heroin addiction	??	??	?? PRIORITY=1	?? 26-May-2004	??

Past Procedures (High priority)

<u>Description</u>	<u>?? Laterality</u>	<u>?? Extension</u>	<u>?? Date Recorded</u>
Medication commenced for pain	??	??	?? 23-Feb-2010
New medication added	??	??	?? 20-Oct-2008

Active Repeat Therapy

Some Repeats may be Active but not Issued. In these instances, the Date Last Issued field contains the date authorised by the GP.

<u>Drug name</u>	<u>?? Drug code</u>	<u>?? Formulation</u>	<u>?? Dosage</u>	<u>?? Frequency</u>	<u>?? Last Issued</u>	<u>??</u>
Naproxen Tablets 500 mg	?? 1001010P0AAAEAE	?? 56 tablet	?? ONE TO BE TAKEN TWICE A DAY	?? -	?? -	?? -
Co-Codamol 30/500 Tablets	?? 0407010F0AAAH	?? 3*224 TABLET	?? TWO TO BE TAKEN UP TO A MAXIMUM OF FOUR TIMES A DAY WHEN REQUIRED FOR PAIN	?? -	?? -	?? -
Amitriptyline Hydrochloride Tablets 25 mg	?? 0403010B0AAAH	?? 3*84 TABLET	?? ONE TABLET ONCE TO THREE TIMES A DAY DEPENDING ON SEVERITY	?? -	?? -	?? -

Issued Scripts for Acutes and Inactive Repeats (in last 90 days)

No recent medications recorded

Clinical warnings

Smoking status: Number per day: ? (not known)

<u>Description</u>	<u>Comment</u>	<u>Date Recorded</u>
Cigarette smoker, 20 Cigarettes/day		26-Jul-2018
Cigarette smoker	Smoking status on date of event: Y	06-Apr-2009

Alcohol status: Units per day: ? (not known)

Exercise status: Not Known

Allergies

<u>Description</u>	<u>Comment</u>	<u>Modifier</u>	<u>Start Date</u>	<u>Recorded Date</u>
Adverse reaction to Tramadol Hydrochloride	-	-	-	-

Additional relevant information

?

Signature of referring doctor (or other professional)

Date

08-Sep-2020

Dr David Borland
Dr Borland & Partners Cchc
Hallpark Road
Sauchie
FK10 3JQ

Date Dictated
Date Typed 16 March 2018
Our Ref PR//3011795258
CHI 3011795258

Discharge Summary

Dear Dr Borland

GARY SCRIMSHAW 30/11/1979
96 TENACRES SAUCHIE ALLOA FK10 3DP

Diagnosis: Chronic back pain

Outcome

- | | |
|-------------------------------------|--|
| <input type="checkbox"/> | Much better / Problem resolved |
| <input type="checkbox"/> | Improved |
| <input type="checkbox"/> | No change |
| <input type="checkbox"/> | Worse |
| <input checked="" type="checkbox"/> | Patient did not complete course of treatment |
| <input type="checkbox"/> | Patient did not attend initial appointment |
| <input type="checkbox"/> | Patient failed to respond to offer of appointment letter |
| <input type="checkbox"/> | Patient declined initial appointment |

Additional Comments:

Gary attended with a 22 year history of chronic back pain. He was given chronic pain advice, exercises and we discussed strategies to manage his pain better. He did not attend his review appointment and has not been back in touch.

Yours sincerely



(Electronically checked by Peter Reid)

Peter Reid



Chairman: Alex Linkston CBE
Chief Executive: Cathie Cowan

Forth Valley NHS Board is the common name for Forth Valley Health Board
Registered Office: Carsview House, Castle Business Park, Stirling, FK9 4SW

www.nhsforthvalley.com  [Facebook.com/nhsforthvalley](https://www.facebook.com/nhsforthvalley)  [@nhsforthvalley](mailto:nhsforthvalley@nhs.uk)

HCPC Registered Physiotherapist

For NHS Forth Valley physiotherapy appointments and queries contact the AHP MSK Hub on 01324 673890 or FV-UHB.AHPMSkHub@nhs.net

Hospital use only	Clinic	Day Date	Time	Hospital No.
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Date Referral Submitted
 (This date is fixed at hospital end):
10-Jan-2018

REFERRAL LETTER

**MEDICAL IN
 CONFIDENCE**

3011795258

CHI No: 3011795258

101015223314Z

Unique Care Pathway Number: 101015223314Z

REFERRAL TO	
Physiotherapy - MusculoskeletalR5V5 FV Physio - Musculoskeletal	? Consultant / receiving practitioner and/or specialty clinic
Forth Valley Royal Hospital Stirling Road Larbert FK5 4WR	? Hospital and hospital address Hospital location code: V217H
Urgency of Referral Routine Physiotherapy - General Musculoskeletal Referral??	
Administrative Information Patient has special requirements: No Ethnic Origin: White Scottish	

PATIENT DETAILS	
Surname: Scrimshaw	Patient's address: 96 Ten Acres Sauchie Alloa FK10 3DP
Forename(s): Gary	
Title: - Sex: Male	Contact number(s)
Previous Surname: -	Voice: 07341940869
Date of birth: 30-Nov-1979	E-mail: garyscrimshaw@gmail.com
CHI no.: 3011795258	

REFERRING PRACTITIONER DETAILS	
Name: Dr. Catriona Lamb (GMC: 2956464)	Practice address: Hallpark Road Sauchie FK10 3JQ
Practice: Dr Borland & Partners CCHC (25031)	
Phone: Voice: 01259 216701	

CLINICAL INFORMATION**History of presenting complaint / examination findings / Investigation results****Presenting Complaint**

Description: Query

Comment: Dear Team,

This gentleman has had ongoing back problems for some considerable time. They seem to be of a mechanical nature having presented to me in May 2017 having overstretched at work causing acute back spasm.

He has been taking Amitriptyline and Co-codamol for some considerable time and was keen to try and come off them however he does suffer significant back pain when does stop his medication.

He was referred to your service in 2015 but failed to respond to offer of an appointment.

His problems date from his time in the Army and the symptoms can vary from left lumbar pain (2015 this caused numbness).

There are no current red flags but I suspect this gentleman needs some general education regarding chronic back pain. Thank you for considering seeing him.

Yours sincerely,

Dr Catriona B Lamb

Examinations and Investigations

Murmur present: Not Recorded -
 Is a 12 lead ECG: Not done -
 Recent CXR: Not done -
 FBC: Not Recorded -
 Urea and Electrolytes: Not Recorded -
 LFT: Not Recorded -
 TFT: Not Recorded -
 Lipid Profile: Not Recorded -
 Glucose: Not Recorded -
 Known risks: None -

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Medical history**Active Repeat Therapy**

Some Repeats may be Active but not Issued. In these instances, the Date Last Issued field contains the date authorised by the GP.

Drug name ?? Drug code ?? Formulation ?? Dosage ?? Frequency ?? Last Issued ??
 Amitriptyline Hydrochloride Tablets 25 mg ?? 0403010B0AAAHAH ?? 168 TABLET ?? 3 Daily ?? - ?? - ?? -

Issued Scripts for Acutes and Inactive Repeats (in last 90 days)

No recent medications recorded

Clinical warnings

Smoking status

Alcohol consumption

Lifestyle risks

Exercise status: Not Known

Not Known

Units per day
? (not known)**Additional relevant information**

?

Signature of referring doctor (or other professional)

Date

10-Jan-2018



NHS Forth Valley Radiology Report

Patient Name:	Scrimshaw, Gary (Mr)	Exam Date:	21/05/2024
Patient ID:	3011795258	Consultant:	BECKETT DR DANIEL CONS MEDIC
Patient Date of Birth:	30/11/1979	Report Date and Time:	22/05/2024 12:54:32
Patient Address:	40 JOHNSTON CRESCENT TILlicOUNTRY CLACKMANNANSHIRE FK13 6PZ	Referring Dept/Location:	FV RACU MEDICAL

Accession: V213936463501, Examination Date: 21/05/2024, Examination:
XR Chest:

Indication:

Clinical Details:

increasing SOB and chest tightness

Provisional Diagnosis :

?pe

Findings:

PA chest:

Comparison is made with chest radiographs dated 20/08/2010.

Cardiomediastinal contours are within normal limits.

Lungs and pleural spaces are clear.

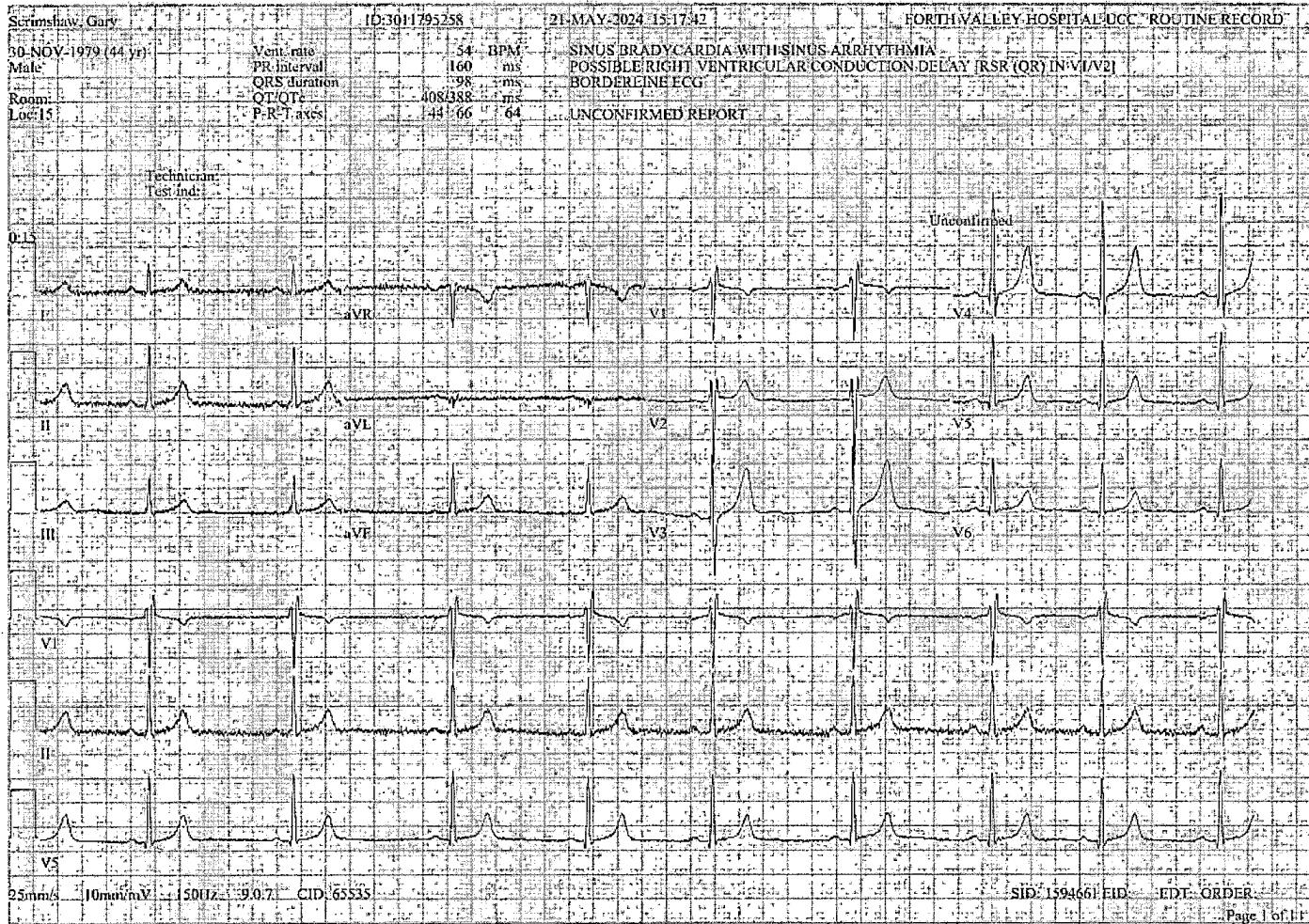
No focal areas of consolidation or collapse.

No pleural effusion.

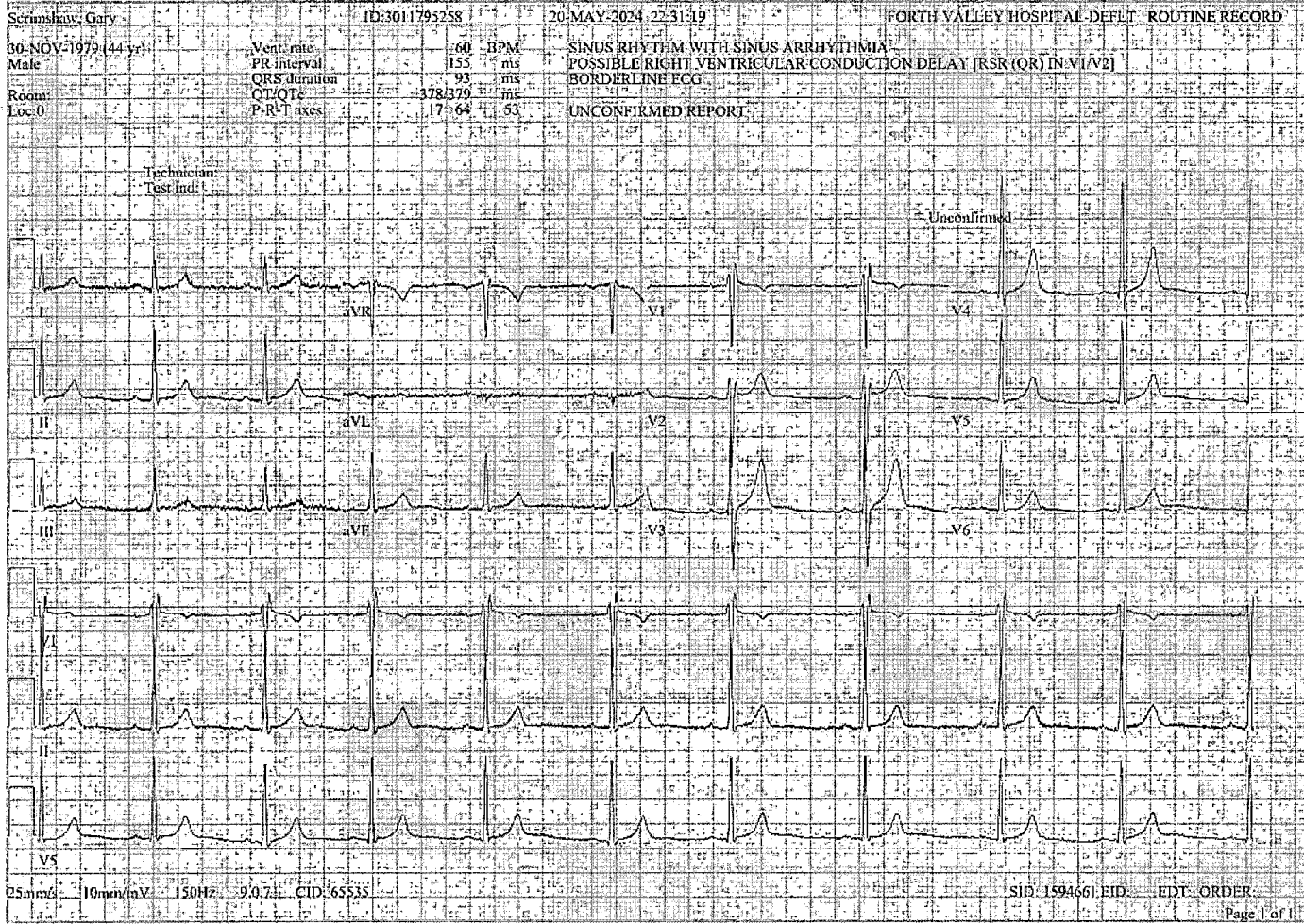
Unremarkable bony thorax.

No radiographic evidence of active pulmonary disease.

Final Report By: Jonathan Mayers Reporting Radiographer HCPC RA78096 at 22/05/2024 12:54:32
Email Address: jonathan.mayers@nhs.scot.



THIS IS A RECONSTITUTED DOCUMENT PRINTED FROM EDRM



THIS IS A RECONSTITUTED DOCUMENT PRINTED FROM EDRM

Medication Administration Profile

Date of Report: 20-Apr-2026 at 14:27 Page 1 of 1

Type of Report: Since Admission

Requested By: JRAE2

Current Status: Discharged

Admitted On: 21-May-2024

Discharged On: 21-May-2024

Patient: Scrimshaw, Gary

Weight: kg

Hospital No: 3011795258 National No: 301 179 5258

Height: cm

Date of Birth: 30-Nov-1979

Body Surface: m²

Allergies: ***Unknown***

Sensitivities:

Episode History:

Consultant: DR DANIEL BECKETT from 21-May-2024 15:11 to 21-May-2024 16:50

Transfer History:

Admitted to Ward: UCC SDEC (FVRH) on 21-May-2024 at 15:11

There are no active medications for this patient.

CCHC

S/237397

L/S 7/Jan

Hospital use only | Clinic

Hospital No.

Date Referral Submitted
(This date is fixed at hospital entry)
10-Jan-2018

SCANNED APPT DETAILS

31/1/80 at 10:15
Debr Reid

PHYSIO.....

LOCATION

CCHC

101015223314Z*

Unique Care Pathway Number: 101015223314Z

REFERRAL TO

Physiotherapy - Musculoskeletal R5V5
FV Physio - Musculoskeletal

Consultant / receiving practitioner
and/or specialty clinic

Forth Valley Royal Hospital
Stirling Road
Larbert
FK5 4WR

Hospital and hospital address

Hospital location code.

V217H

Urgency of Referral

Routine Physiotherapy - General 11/1/18 LC
Musculoskeletal Referral veteran - send letter out

Administrative Information

Patient has special requirements: No
Ethnic Origin: White Scottish

PATIENT DETAILS

Surname	Scrimshaw		
Forename(s)	Gary		
Title	-	Sex	Male
Previous Surname	-		
Date of birth	30-Nov-1979		
CHI no.	3011795258		

Patient's address

96 Ten Acres
Sauchie
Alloa
FK10 3DP

Contact number(s)

Voic: 07341940869 / 07511670402
E-mail: garyscrimshaw@gmail.com

REFERRING PRACTITIONER DETAILS

Name: Dr. Catriona Lamb (GMC: 2956464)
Practice: Dr Borland & Partners CCHC (25031)
Phone: Voic: 01259 216701

Practice address:

Hallpark Road
Sauchie
FK10 3JQ

dic on eoms

CLINICAL INFORMATION

History of presenting complaint / examination findings / Investigation results

Presenting Complaint

Description: Query

Comment: Dear Team,

This gentleman has had ongoing back problems for some considerable time. They seem to be of a mechanical nature having presented to me in May 2017 having overstretched at work causing acute back spasm.

He has been taking Amitriptyline and Co-codamol for some considerable time and was keen to try and come off them however he does suffer significant back pain when does stop his medication.

He was referred to your service in 2015 but failed to respond to offer of an appointment.

His problems date from his time in the Army and the symptoms can vary from left lumbar pain (2015 this caused numbness).

There are no current red flags but I suspect this gentleman needs some general education regarding chronic back pain. Thank you for considering seeing him.

Yours sincerely,

Dr Cabriona B Lamb

Examinations and Investigations

Murmur present: Not Recorded -
 Is a 12 lead ECG: Not done -
 Recent CXR: Not done -
 FBC: Not Recorded -
 Urea and Electrolytes: Not Recorded -
 LFT: Not Recorded -
 TFT: Not Recorded -
 Lipid Profile: Not Recorded -
 Glucose: Not Recorded -
 Known risks: None

Patient Measurements

<u>Diastolic</u>	<u>Systolic</u>	<u>Height</u>	<u>Weight</u>	<u>BMI</u>	<u>Date Recorded</u>
120	70				13-Jan-2011
110	70				30-Jun-2006
110	70				30-Jun-2006
		169	67.55	23.65	13-Jan-2011
		171	64		30-Jun-2006

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Medical history

Active Repeat Therapy

Some Repeats may be Active but not Issued. In these Instances, the Date Last Issued field contains the date authorised by the GP.

<u>Drug name</u>	<u>Drug code</u>	<u>Formulation</u>	<u>Dosage</u>	<u>Frequency</u>	<u>Last Issued</u>
Amitriptyline Hydrochloride Tablets 25 mg	0403010B0AAHAH.	168-TABLET	3	Daily	

Issued Scripts for Acutes and Inactive Repeats (in last 90 days)

No recent medications recorded

Clinical warnings

Smoking status: Number per day: ? (not known)

<u>Description</u>	<u>Comment</u>	<u>Date Recorded</u>
Current smoker		29-Dec-2017
Current smoker		03-Jul-2015
Current smoker		24-Sep-2013
Trying to give up smoking		13-Jan-2011
Cigarette smoker, 10 Cigarettes/day -		13-Jan-2011
Alcohol status: Units per day: ? (not known)		
<u>Description</u>	<u>Comment</u>	<u>Date Recorded</u>
Alcohol consumption, 0 units/week		13-Jan-2011
Teetotaler	Disease: SPICE Basic Health Values, priority=2	30-Jun-2006
Exercise status: Not Known		
<u>Description</u>	<u>Comment</u>	<u>Date Recorded</u>
Aerobic exercise 0 times/week		13-Jan-2011
Enjoys moderate exercise	Disease: SPICE Basic Health Values, priority=2	30-Jun-2006
Additional relevant information		

Signature of referring doctor (or other professional)	Date	10-Jan-2018
--	-------------	-------------

Screening Assessment

Patient's Name: Gay Scripshaw CHI/DOB: 3011795258 Page: 4

Date: 31/01/18

General Health	<u>Allyant</u>
Investigations	<u>Nil</u>
Hospital Appts	<u>Nil</u>
PMH	<u>Nil of note</u>
Drug History	<u>Co-codamol</u>

✓ = No problem, ✗ = Problem identified, N/A = Not applicable to patient, Do not leave blanks

Number of Red Flags	Health Parameters	✓/✗/NA	Comments
<input type="checkbox"/>	Age 11-19 / <10 >55		
<input type="checkbox"/>	Ca/FHX of Ca	✓	
<input type="checkbox"/>	Weight loss >10% / 5-10% / <5%		
<input type="checkbox"/>	Statins	✓	
<input type="checkbox"/>	Diabetes	✓	
<input type="checkbox"/>	Epilepsy	✓	
<input type="checkbox"/>	Cardiovascular	✓	
<input type="checkbox"/>	Blood Pressure	✓	
<input type="checkbox"/>	Previous Strokes / TIA	✓	
<input type="checkbox"/>	Respiratory / Asthma	✓	
<input type="checkbox"/>	Persistent Cough	✓	
<input type="checkbox"/>	Infection / Fevers / Viruses	✓	
<input type="checkbox"/>	HIV / Drug abuse	✓	
<input type="checkbox"/>	Night Sweating / Severe Pain	✓	
<input type="checkbox"/>	Anticoagulants	✓	
<input type="checkbox"/>	Thoracic Pain	✓	
<input type="checkbox"/>	Steroid Use / Osteoporosis	✓	
<input type="checkbox"/>	RA / FHX of RA	✓	
<input type="checkbox"/>	Other Joint Pain	✓	
<input type="checkbox"/>	Allergies - Latex - Elastoplast	✓	

Physiotherapist Name: Peter Lynch - Student PT Signature: Peter Lynch

Alan P. O. (B6PT)

Patient's Name: Greg Scrimshaw CHI/DOB: 30/11/795258 Page: 5

Number of Red Flags	Health Parameters	✓/X/NA	Comments
	LUMBAR SPINE		
■ ■	Bladder / Bowel	✓	
■ ■ ■	Saddle Anaesthesia	✓	
	Cough / Sneeze	✓	
■ ■ ■	Cord Signs	✓	
■ ■	Inability To Lie Supine	✓	
	CERVICAL SPINE		
■	Dizziness		/
■	Diplopia		
■	Dysphagia		
■	Dysphasia		
■	Drop Attacks		
■ ■ ■	Cord Signs		
	PERIPHERAL JOINTS		
	Locking		
	Giving Way		
	Immediate Swelling		

Yellow Flags	Comments
Worries/Anxieties	Not Paralytic. Learned to live with it.
Perceptions	Muscular
Quality of Life	↓ QoL. Limbs activities

Blue Flags	Comments
Currently Off Work	Please Circle: Yes <input type="radio"/> No <input checked="" type="radio"/> N/A <input type="radio"/>
Time Off	
What Changes will Allow You To Work?	

Shared Goals	Date Set	Target Date	Barriers	Achieved Y/N
Mange P/Blue - wks.	3/1/18			

Physiotherapist Name: Peter Lynch - Student PT Signature: Peter Lynch

Re-Order Ref: TF/1005/MECR

Alan Parsons (BPT)

Review Date: 2019

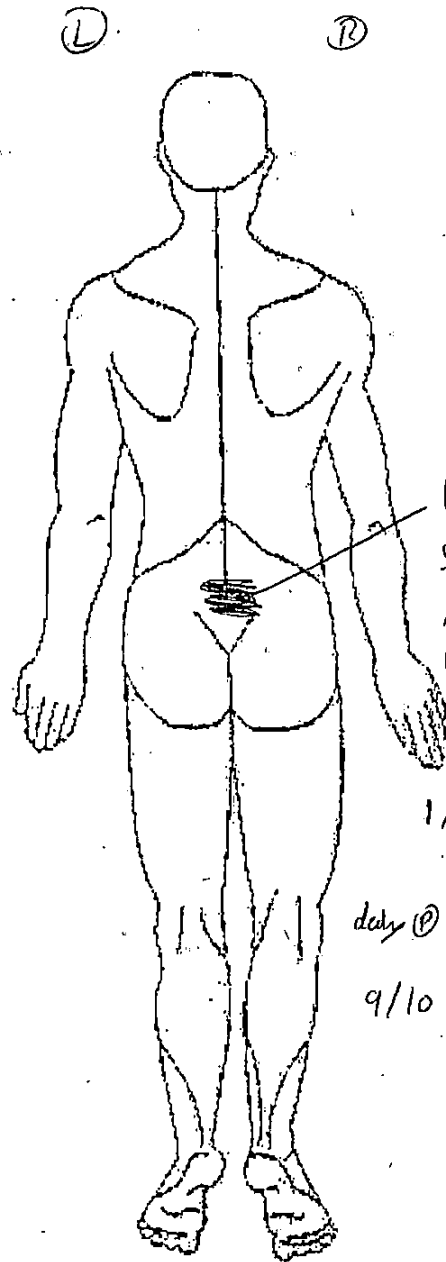
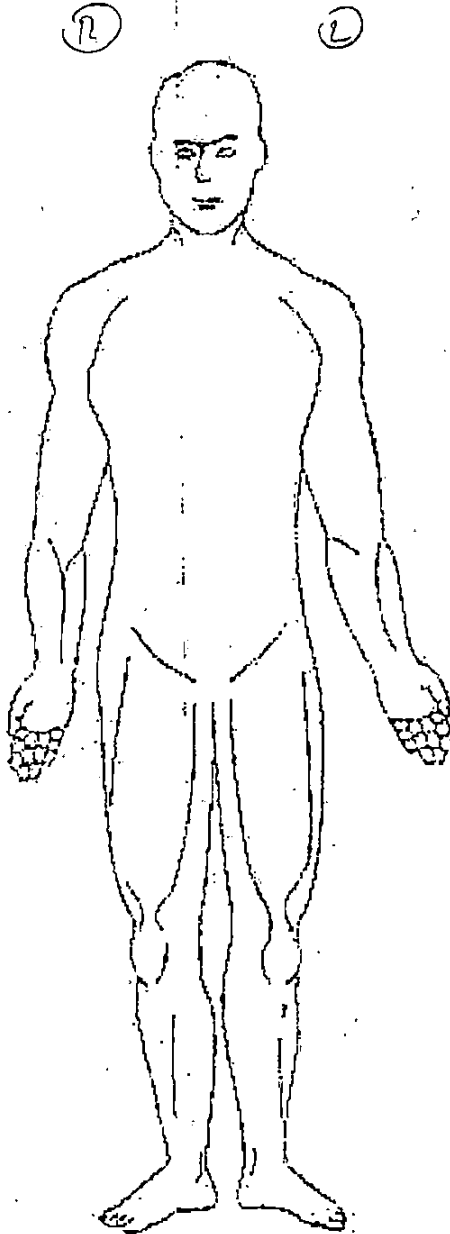
Name: Gary Scrimshaw CHI 3011795258

Date: 31/01/18

Page No: 6

Aggs: • Cold weather
• Bending forward / twisting / rotate

Cases: • Sitting & legs arched & pillow underneath.
"Taking arch out of back"



(P1)
Sharp / Stabbing
I/M.
Worse & ↑ activity
& Cold.

1/10 : now
= P
daily @ 5/10 @ lat Pk's
9/10 : at worst

24 hour Pattern: A.m: } depends on activity. P @ & ↑ activity.
P.m: }

Nights Disturbed sleep wakes up couple times in night. Trying to get comfortable.

Physiotherapist Name: Peter Lynch - Student P Signature: Peter Lynch

Alan P. [Signature]

Name: Gary Scrimshaw CHI: 3011795258

S/E: Date: 31/01/18 Page No: 7

P.c. Baek (P)

H.P.C. 22/1 ago. In army. Carrying weights on back. collapsed one day. Men running/braking, stretched away. sudden onset of P in Lx. Had 26b riggles i previous braking but this event was very painful. Army PTs said PB had ↑ Lx lordosis which predicted problem. S.H. = missing scans. NAD. ↑ lordosis caused "forecast nerves". Tried swimming, heat, yoga poses, etc, nothing really helped.

- Lives in W.C. + kids (3 + 11)
- Amazon. In warehouse. Always on feet picking orders. 10 hr shifts.
- Cycling. maintaining biking. Restricted i.e. flex is flare-ups.

O/E: obs: - PB looked quite lethargic. Looked generally unwell.
- ↓ Lx lordosis. Straight back posture.
- ↑ erector spinae activation. (P) > (L)

Lx: AROM

Flex: Hands to knees (P)

Ext: 1/2 range (P)

(P) Side Flex: 3/4 range (P) little (L)

(L) Side Flex: 1/2 range (P) (P) Lx

Hips: ✓✓

Knees: ✓✓

Neuro: ✓✓

Palp: (P) on PALMIS Lx Spinous Processes L2 - L5. (P) above PL

Imp: Mechanical LBP.

Rx: (1) Explanation of findings

(2) Advice + discussion R.E. Pacing activities when feeling "bunage" prior to flare-up.

Flare-up:

(3) HEP: knee hugs (30 sec holds x 3 throughout day), Childs Pose (1/2 x 3 sets throughout day) & Seated trunk flex / touch the floor (30 sec holds x 3 sets throughout day)

(4) Explanation for reasoning for particular ex's; Emphasis + of importance of maintaining ex's regularly

P: R/V 1/5.2. ↑ ex's as able.

Physiotherapist Name: Peter Lynch - Student PT Signature: Peter Lynch

T

TC

2/1/22/9

SCANNED APPT DETAILS 9/10/20 1pm

Hospital use only | Clinic | Hospital No.

Date Referral Submitted
(This date is fixed at hospital)
08-Sep-2020

PHYSIO.....
LOCATION..... **CGH, C... ER**
MEDICAL IN CONFIDENCE

Dupatt.

3011795258

CHI No: 3011795258

101021629631U

Unique Care Pathway Number: 101021629631U

REFERRAL TO	
Physiotherapy - Musculoskeletal(R5V5) FV Physio - Musculoskeletal	— Consultant / receiving practitioner and/or speciality clinic
Forth Valley Royal Hospital Stirling Road Larbert FK5 4WR	— Hospital and hospital address Hospital location code: <u>V217H</u>
Routine Physiotherapy - General Musculoskeletal Referral	
Urgency of Referral	
Administrative Information Patient has special requirements: No Ethnic Origin: (White) British	

PATIENT DETAILS	
Surname: <u>Scrimshaw</u>	Patient's address 40 Johnstone Crescent Tillicoultry FK13 6PZ <i>96 TEA area Dachia FK10 3DP</i>
Forename(s): <u>Gary</u>	
Title: - Sex: <u>Male</u>	
Previous Surname: -	
Date of birth: <u>30-Nov-1979</u>	
CHI no: <u>3011795258</u>	Contact number(s) Voice: 07340830479 E-mail: garyscrimshaw@gmail.com

REFERRING PRACTITIONER DETAILS	
Name: Dr. Andreas Kollé (GMC: 4269506)	Practice address: Park Street Tillicoultry FK13 6AG
Practice: Tillicoultry Medical Practice (25544)	
Phone: Voice: 01259 750531	

DIC

CLINICAL INFORMATION

History of presenting complaint / examination findings / investigation results

Presenting Complaint

Description: Assessment.

Comment: This 40 year old gentleman works in a factory filling bottles. He has a 4 month history of a painful right shoulder. He points to the regimental badge area on the top of the shoulder, at the back as well. He has limited arc, being able to elevate the arm sideways up to 80 degrees and is unable really to move to a position if he wanted to pour out bottle.

I would be grateful for your further assessment and advice. He asked for some exercises to do and I gave him a link to NHS Inform - musculo skeletal zone to start with. He is already on Co-codamol and Amitriptyline for back problems and I have added some Naproxen today.

Thank you very much.

Kind regards.

Dr A'E Kelle
Typed 08.09.2020 - FG

Examinations and Investigations

Murmur present: Not Recorded -
Is a 12 lead ECG: Not done
Recent CXR: Not done
FBC: Not Recorded -
Urea and Electrolytes: Not Recorded -
LFT: Not Recorded -
TFT: Not Recorded -
Lipid Profile: Not Recorded -
Glucose: Not Recorded -
Known risks: None

Patient Measurements

Diastolic	Systolic	Height	Weight	BMI	Date Recorded
109	60				17-Aug-2010

Reason for referral

Care type requested: Out Patient
Expected outcome: Investigate

Medical history

Pre-existing Conditions (High Priority)

Description	Laterality	Modifier	Extension	Date Started
[X]Heroin addiction			PRIORITY=1	26-May-2004

Past Procedures (High priority)

Description	Laterality	Extension	Date Recorded
Medication commenced for pain			23-Feb-2010
New medication added			20-Oct-2008

Active Repeat Therapy

Some Repeats may be Active but not Issued. In these instances, the Date Last Issued field contains the date authorised by the GP.

Drug name	Drug code	Formulation	Dosage	Frequency	Last Issued
Naproxen Tablets 500 mg	1001010P0AAAEE	56 tablet	ONE TO BE TAKEN TWICE A DAY		
Co-Codamol 30/500 Tablets	0407010F0AAAH	3*224 TABLET	TWO TO BE TAKEN UP TO A MAXIMUM OF FOUR TIMES A DAY WHEN REQUIRED FOR PAIN		
Amitriptyline Hydrochloride Tablets 25 mg	0403010B0AAAH	3*84 TABLET	ONE TABLET ONCE TO THREE TIMES A DAY DEPENDING ON SEVERITY		

Issued Scripts for Acutes and Inactive Repeats (In last 90 days)

No recent medications recorded

Clinical warnings

Smoking status: Number per day: ? (not known)
Description Comment Date Recorded
Cigarette smoker; 20 Cigarettes/day - 26-Jul-2018
Cigarette smoker Smoking status on date of event: Y 06-Apr-2009

Alcohol status: Units per day: ? (not known)

Exercise status: Not Known

Allergies

<u>Description</u>	<u>Comment</u>	<u>Modifier</u>	<u>Start Date</u>	<u>Recorded Date</u>
Adverse reaction to Tramadol Hydrochloride				

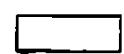
Additional relevant information

Signature of referring doctor (or other professional)	Date	08-Sep-2020
---	------	-------------

1

Route 5/10/2020 W

SCH Minor Injuries Stirling Community Hospital



Date of attendance: 02/10/2020 10:14
Presenting complaint: r shoulder inj

Surname: Scrimshaw	Forename: Gary	Title: Mr
Address: 40 Johnston Crescent	Postcode: FK13 6PZ	CHI: 3011795258
Tillicoultry Clackmannanshire		RECEIVED 05 OCT 2020
Telephone: 07340830479		
Date of Birth: 30/11/1979	Sex: Male	Age: 40 Years

GP Name: AE Kelle	Telephone: 01259 750531
Address: 25544/1 Tillicoultry Medical Practice Park Street Tillicoultry Tillicoultry FK13 6AG	

Next of Kin	
Name: Tracey Scrimshaw	Postcode: FK13 6PZ
Relationship: Wife	Telephone: 07423556817
Address: 40 Johnston Crescent Tillicoultry Clackmannanshire	

Triage Information

Observations

P= BP= / RR= Sat= BM= Temp=

Peak Flow= GCS= News=

Emergency Department / Pre-Hospital Drugs		Allergies				
Date	Drug	Dose	Route	Signature	Given by	Time

MYLO
REF
A+ME

Emergency Discharge Letter (Authorised)

AE Kolle
Tillicoultry Medical Practice
Park Street
Tillicoultry
Tillicoultry
FK13 6AG

SCH Minor Injuries
Livilands Gate
Stirling
Stirling
Stirlingshire
FK8 2AU

Dept. Contact Details:

CHI Barcode:



3011795258

Date of Completion: 02-Oct-2020

GP Practice			
GP Name:	AE Kolle	GP GMC:	4269506
GP Practice Address:	Tillicoultry Medical Practice Park Street Tillicoultry Tillicoultry FK13 6AG	GP Practice Code:	4269506/25544
		GP Clinic Code:	25544/1
		GP Telephone:	01259 750531

Patient Demographics			
Patient Name:	SCRIMSHAW, Gary	Date Of Birth:	30-Nov-1979
Patient Address:	40 Johnston Crescent Tillicoultry Clackmannanshire FK13 6PZ	Gender:	Male
		CHI No:	3011795258
Telephone No:	07340830479		

Admission Details			
Patient Location:	SCH Minor Injuries	Admission Date:	02-Oct-2020
Admission Care Provider:	Dr Joanne Mitchell	Admission Time:	10:14
Source Of Admission:	Not Known		

Presenting Complaint	
r shoulder inj	

Diagnosis		
Diagnosis	Site	Laterality
Calcific Tendinitis of Shoulder		

Procedures	
No Procedure Results	

Medications	
Nil records exist	

Discharge Details			
Discharge Type:	With referral	Discharge Date:	02-Oct-2020
Discharge Destination:	Private Residence - Usual place of residence	Discharge Time:	13:17

Referred To: Physiotherapy

Notes for GP

PC: Right shoulder injury.
HPC: Fall from bike hitting bollard. Pain in right shoulder since. Already has pain in shoulder since previous fall. No head injury.
PMH: Nil
Symptoms: Pain anterior right shoulder. No altered neuro
OE: No obvious swelling, erythema, bruising, deformity.

Neck NAD

Shoulder- flex 90, Abd 90 LR full. Pain with hand behind back.

MP 5/5 with pain on abd and LR.

Drop arm -ve

NV intact.
X-RAY: No # seen. RC calcification.
Treatment: Collar and cuff. 1 - 2 days. Shoulder advice sheet.
Plan: Physio
GP Action: Nil

Person completing record

Name:	Specialty:	
Designation or role:	Date completed:	02-Oct-2020

Distribution List

Recipient Name	Recipient Type	Recipient Organisation
AE Kelle	GP	Tillicoultry Medical Practice

Gary Scribble 30/11/79

Schizophrenia disease

PMH: /

MEDS: - Amitriptyline (since Apr 17) x2-3 (25mg tablets)
- Naproxen
- Co-codamol 30/500 x8 (hours) this is for
SH: Schevermann's

(2)

GH: T...H...R...E...A...D...S

H/o CA self? Y (N)

Recent weight loss? Y (N)

- Marks on Boney (physical +)
- Cycle
- Has x2 children (S, B)

ANY PERTINENT RED FLAG QUESTIONS:

S O'S -ve

OBSERVATIONS:

Q. Rott: ✓ GH Dec: 80
Apt 90
HBB L

elbow/wrist/hand ✓

△ frame?
calcification?

TREATMENT/DISCUSSION

HER (enrol B) see assessment
bad management, aggression; POLICE + PEACE AND LOVE

PLAN

RZF in 4s2
pt happy to plan

dobier Anzitepide BGPT
09/10/2020



Personal exercise program

Physiotherapy exercises

NHS Forth Valley
NHS Forth Valley
Unit 2 Colquhoun Street, FK10 3BJ, Stirling, United Kingdom

Provided by Xabier Ariztegieta
Provided for Gary Scrimshaw.

8-20 x 2-3

As able



©Physiotoools

Sit. Hold a stick upright in front of you as far away as possible from your body with the end of the stick resting on the floor.

Lean forwards.

Repeat _____ times.

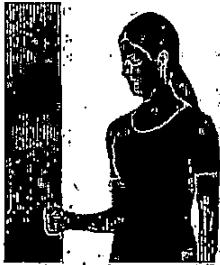


©Physiotoools

Lying on your back with elbows straight.

Use one arm to lift the other arm up keeping it as close to the ear as possible.

Repeat _____ times.



©Physiotoools

Stand with your upper arm close to your side, elbow at a right angle and the back of your hand against a wall.

Push the back of your hand against the wall. Hold approx. _____ secs.

Repeat _____ times.



©Physiotoools

Stand or sit. Hold your upper arm close to your body with your elbow at a right angle.

Try to move your hand outward, resisting the movement with the other hand. There should be no movement.

Hold _____ seconds.

Repeat _____ times.

Gary Scrimshaw 30/11/19

16/10/11

f/c in own - r could be as - r. However pt r scheduled
apt afterwards (through the HWS) on the as lot computer

coming to the department

pt reported feeling 100% better in or f/c

(1) f/c in 11/52 DIC? X Anztygels 36P

20/10/20

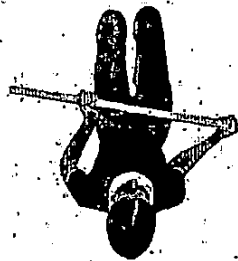
PTA. nurse to left in on inside nurse

(1) on hold for 2152. X Anztygels

3/11/20

No further contact made. DIC

X Anztygels



©Physiotools

Lying on your back with elbows against your body and at a right angle. Hold a stick in your hands.

Move the stick sideways thus pushing the arm to be exercised outwards.

Repeat _____ times.



©Physiotools

Lie on your back. Hold a _____ kg weight.

Lift your arm keeping your elbow straight.

Repeat _____ times.



©Physiotools

Stand with feet apart. Hold a stick or weight with both hands close together.

Lift the stick/weight to your chin. Your elbows should point outwards and upwards while doing the exercise.

Repeat _____ times.



©Physiotools

Sit or stand with hands clasped in front of you.

Lift your hands above your head and stretch your arms as far back as possible.

Repeat _____ times.



Personal exercise program

Physiotherapy exercises

NHS Forth Valley

NHS Forth Valley

Unit 2 Colquhoun Street, FK10 3BJ, Stirling, United Kingdom

Provided by Xabier Ariztegieta
Provided for Gary Scrimshaw



©Physiotools

Sit. Hold a stick upright in front of you as far away as possible from your body with the end of the stick resting on the floor.

Lean forwards.

Repeat _____ times.



©Physiotools

Lying on your back with elbows straight.

Use one arm to lift the other arm up keeping it as close to the ear as possible.

Repeat _____ times.



©Physiotools

Stand with your upper arm close to your side, elbow at a right angle and the back of your hand against a wall.

Push the back of your hand against the wall. Hold approx. _____ secs.

Repeat _____ times.



©Physiotools

Stand or sit. Hold your upper arm close to your body with your elbow at a right angle.

Try to move your hand outward, resisting the movement with the other hand. There should be no movement.

Hold _____ seconds.

Repeat _____ times.

Immediate Discharge Letter (Authorised)

COPY

G Campbell
Tillicoultry Medical Practice
Park Street
Tillicoultry
Tillicoultry
FK13 6AG

Acute Medicine
Stirling Road
Larbert
Larbert
Stirlingshire
FK5 4WR

Dept. Contact Details:

CHI Barcode:



3011795258

Date of Completion: 21-May-2024

Patient Demographics			
Patient Name:	SCRIMSHAW, Gary	Date Of Birth:	30-Nov-1979
Patient Address:	40 Johnston Crescent Tillicoultry Clackmannanshire FK13 6PZ	Gender:	Male
		CHI No:	3011795258
Telephone No:	07340830479		

GP Practice			
GP Name:	G Campbell	GP GMC:	7277373
GP Practice Address:		GP Practice Code:	7277373/25544
		GP Clinic Code:	25544
		GP Telephone:	

Admission Details			
Patient Location:	Acute Medicine	Admission Care Provider:	Dr Daniel Beckett
Admission Date:	21-May-2024	Admission Time:	15:11
Admission Method:	Emergency Admission, no additional detail added	Ward:	FVRH UCC SDEC
Source Of Admission:	GP Non Obstetrics - other Provider		

Discharge Details			
Discharge Specialty:	Acute Medicine	Discharge Care Provider:	Dr Daniel Beckett
Discharge Date:	21-May-2024	Ward:	FVRH UCC SDEC
Discharge Time:	16:49	Discharge Destination:	Private Residence - no additional detail added
Discharge Method:	Regular discharge, no additional detail added		

Clinical Summary including History	
Dear Dr,	
Gary attended RACU with 1/52 history of chest tightness and SOB intermittent in nature. Non exertional. Describes episode yesterday severe with associated clamminess with palpitations whilst at work. No cough/ feverish symptoms/ nausea.	
Obs/ BP 131/82 hr 54 rr16 O2 98% ra. temp 36.3C	
OE/ pulse reg HS I+II+O chest clear	
ECG nsr	
CXR nad	
Bloods checked in ED 20/5 no change in presentation normal FBC, UES, LFTs, troponin. D dimer checked today normal.	

Imp/ MSK injury / stress

Plan:
Home with worsening statement.**COPY**

Should you require any further information please contact RACU.

Kind regards, Dr Catriona Parker GPWSI acute medicine

Safety Alerts

Nil records exist

Allergy/Intolerance

Allergy records are as recorded at time and date of printing

Nil records exist

Medications**Drug Information:**

Drug	Dose	Route	Frequency	GP to Continue	POD	Days Supply
------	------	-------	-----------	----------------	-----	-------------

Nil records exist

Drug Notes:

Drug	Drug Notes
------	------------

Nil records exist

Additional Medicine Information:

Medicines discontinued during admission (Medicines that patient was recorded as admitted on only)

Drug	Discontinued Reason
------	---------------------

Nil records exist

GP Communications:**Outstanding Results**

Responsibility of Hospital

Nil records exist

Person completing record**Authorised by**

Name:

Designation or role:

Specialty:

Date completed:

21-May-2024

Clinically completed by

Name:

Designation or role:

Specialty:

Distribution List

Recipient Name

G Campbell

Recipient Type

GP

Recipient Organisation

Tillicoultry Medical Practice

Imp/ MSK injury / stress

Plan/
Home with worsening statement**COPY**

Should you require any further information please contact RACU.

Kind regards, Dr Catriona Parker GPWSI acute medicine

Safety Alerts

Nil records exist

Allergy/Intolerance

Allergy records are as recorded at time and date of printing

Nil records exist

Medications**Drug Information:**

Drug	Dose	Route	Frequency	GP to Continue	POD	Days Supply
------	------	-------	-----------	----------------	-----	-------------

Nil records exist

Drug Notes:

Drug	Drug Notes
------	------------

Nil records exist

Additional Medicine Information:

Medicines discontinued during admission (Medicines that patient was recorded as admitted on only)

Drug	Discontinued Reason
------	---------------------

Nil records exist

GP Communications:**Outstanding Results****Responsibility of Hospital**

Nil records exist

Person completing record**Authorised by**

Name:

Designation or role:

Specialty:

Date completed:

21-May-2024

Clinically completed by

Name:

Designation or role:

Specialty:

Distribution List

Recipient Name

G Campbell

Recipient Type

GP

Recipient Organisation

Tillicoultry Medical Practice

Date of arrival: 21/05/24 Time of arrival: 15:00
 Source of referral: GP ED Other SAS
 GP Practice: Tillicoultry

CHI: 3011795258 30/11/1979 M 44
 Name: SCRIMSHAW, Gary
 40 Johnston Crescent
 Tillicoultry
 Clackmannanshire
 FK13 6PZ
 Address:
 Telephone Number: 07340830479

COPY

NOK Name: Tracey
 Address:
 Telephone Number: 07423556817
 Relationship: Wife

ALLERGIES:
 NOKA

Reason for assessment:
 chest pain

Medications:
 Co-codamol 30/500 x2
 naproxen 500mg qd
 Omeprazole 10mg
 capasal
 AMT 20mg ON

Name: Victory Adebayo
 Signature: *Victory*
 Date: 21/05/24
 Time: 15:05

PATIENT WELLBEING IN RACU.

COPY

Patient welcomed and orientated to the unit: **Yes/No**

Refreshments offered: **Yes/No**

Patient in Unit for 4 hours or longer: Care and Comfort round commenced: **Yes**

Frailty Patients: Care and Comfort round commenced on admission: **Yes**

Patient requires hospital admission: Care and Comfort round commenced: **Yes**

Non Ambulatory Patients: Care and Comfort round commenced on admission: **Yes**

NURSING NOTES:



(addressograph)

3011795258 30/11/1979 M
SCRIMSHAW, Gary
40 Johnston Crescent
Tillicoultry
Clackmannanshire
FK13 6PZ

COPY

Assessment

Presenting Complaint:

CP + SOB

HPC:

1/52 history of intermittent chest tightness
and SOB non exertional severe episode last
night.
no cough/fevers attended ED.
feels worse
no nausea ECG + bloods
didn't wait for
results
assoc clamminess
+ palpitations

no weight loss

Systemic Enquiry:

1 ~~hr~~ PM overnight more

PMH:

nil

Social History:

Smoking/Vape: 20/day No/Yes pack years

Alcohol: Units/week nil

Live with: wife

Support/carers:

Occupation: works in a Brewery

Family History:

dad - stroke

(addressograph) 3011795258 30/11/1979 M
 SCRIMSHAW, Gary
 40 Johnston Crescent
 Tillicoultry
 Clackmannanshire
 FK13 6PZ

COPY

EXAMINATION

<p>Cardiovascular</p> <p>Pulse 151/11/10</p> <p>16p R) 131/82 L) 120/71 HR 54</p>	<p>Respiratory</p> <p>RR 16 O2 98% - RA</p>
<p>Abdominal</p>	<p>Other Exam</p> <p>T36-30</p>

Neurological (remember speech, visual assessment, balance, gait)

Cranial Nerves:

	R arm	L arm	R Leg	L Leg
Tone				
Power				
Sensation				
Coordination				
Reflexes				

ECG: enlarged cQRs V3-V5 ?LVH.
 ?R)BBB. similar to prior yesterday
 20/5 in 512

CXR: a/w

Name: *ln* **Sign:** *eparker* **Date:** 21/5/24 **Time:** 1600

(addressograph)

3011795258 30/11/1979 M
SCRIMSHAW, Gary
40 Johnston Crescent
Tillicoultry
Clackmannanshire
FK13 6PZ

COPY

Impression:

? MSK
exclude PE

Plan:

Moods in ED yesterday trop S
DUEs, PBC
no nosehigh presentation therefore
cardiac ~~as~~ cause unlikely.
EKG → nad
check D. Drumer ☹️
H) ~ MSK

Name:	Sign:	Date:	Time:
		21/5/24	1545

Patient Information
GARY SCRIMSHAW
 Date: 21/05/2024
 Incident Number: CR010942614
 Age/Gender: 44y Old
 Address: 40 JOHNSTON CRESCENT TILlicOUNTRY, FK13 6PZ
 Incident Type: EMG
 DOB: 30/11/1979
 Incident Location: 40 JOHNSTON CRESCENT TILlicOUNTRY, FK13 6PZ
 CHI: 3011795258
 Ethnicity:



Presenting Complaint

CHEST PAIN

Additional Comments

Nhs 24 call for a 44yom o/a pt was sitting outside with family, pt gcs 15, alert, orientated, good colour and talking in full sentences. Pt has had ongoing chest pain for the past week, pt work called for an ambulance yesterday as pt felt he was going to pass out and had chest pain radiating down his arms, pt was taken to fvrh where he self discharged due to needing to be home for child care, pt had bloods and ecg but did not receive any results. Pt called nhs 24 this morning due to ongoing chest tightness and the feeling his heart is bruised. Pt is under alot of stress at work but normally is not effected by stress o/e all obs are as charted below, pt ecg NSR, chest clear in all fields, pt has not been doing any unusual heavy lifting from his normal amount, pt has not had and blunt force trauma to his chest, pt does not have a cough or bringing up phlegm, socrates filled out, crew called low risk chest pain who accepted pt at racu. Not aware of any family history of cardiac problems, Pt transported to racu for further assessment. nok-wife- tracey-07423556817

PATIENT ASSESSMENT

ACVPU Alert **<C>** No

A Clear

B Breathing Adequately Yes Respiratory Rate 16 SPO2 98

Oxygen Given No

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

C Pulse Rate 74 BP 139/79 Cap Refill <=2 Secs ECG Rhythm Sinus Rhythm

Rhythm Reg Arm Right Central/Peripheral Periphera ECG 12 Lead

D GCS 15 Eyes Spontaneously (4) Voice Orientated (5) Motor Obeys Commands (6) PEARL N/A

Observations

Time	P	RR	BP	SpO2	CR	GCS	ACVPU	ETCO2	T	BM	ECG	P(L)	P(R)	PEF	CrewID
14:20	68	16	130/75	97	<=2s	15	Alert		36.8	6.9	Sinus Rhythm				E9886022
13:57	74	16	139/79	98	<=2 Secs	15	Alert		36.8	6.9	Sinus Rhythm				E9886022

NEWS2

Time	RR	SpO2 Scale 1	SpO2 Scale 2	Air/O2	BP	P	ACVPU	T	Total
14:20	16 (0)	97 (0)		0	130 (0)	68 (0)	Alert (0)	36.8 (0)	0

13:57 16 (0)

98 (0)

0

139 (0)

74 (0)

Alert (0)

36.8 (0)

0

HISTORY

AMPLE

COPY

Allergies	TRAMADOL
Medication	Co-codamol, Naproxen, Omeprazole, Amitriptyline
Past Medical History	SHERMANS DISEASE
Last Eaten	>4 Hours Ago
Events Prior	ON GOING CHEST PAIN

Social History:

Lives alone	No	Living With	WIFE	Patient Occupation	BREWERY OPERATIVE
Patients General Appearance	Normal				
Patient Mobility	Fully Mobile				
Patient Communication	No Help Required				
Patient Clinical Risk Factors	Smoker				
Patient Environmental Risk Factors	None Identified				

SOCRATES

Site	CENTRE OF CHEST	Onset	ONGOING, 14/05/2024
Character	TIGHTNESS, Intermittent	Radiates	No
Associated Symptoms	Dizziness	Exacerbating Or Relieving Symptoms	NIL

MEDICAL

CLOSE RECORD

Treatment On Scene	Non-Emergency		
Transport To Hospital	Normal driving	Pre-Alert	No

INCIDENT LOG

Time Call Received	12:45	Allocated	13:25	Mobile	13:25
First Resource On Scene		Crew On Scene	13:53	Crew Left Scene	14:23
Crew At Hosp		Receiving Hospital	FORTH VALLEY ROYAL HOSPITAL	Clear Time	
Crew ID		Crew Grade		Driver	
E9887673		Paramedic		YES	
E9886022		Ambulance Technician		NO	

Last: Scrimshaw
First: Gary
ID: 301179525B
DOB: 30-Nov-1979
Age: 44yr
Comment:
Tech:
Ref Phys:

Sex: Male

21-May-2024 15:17:42

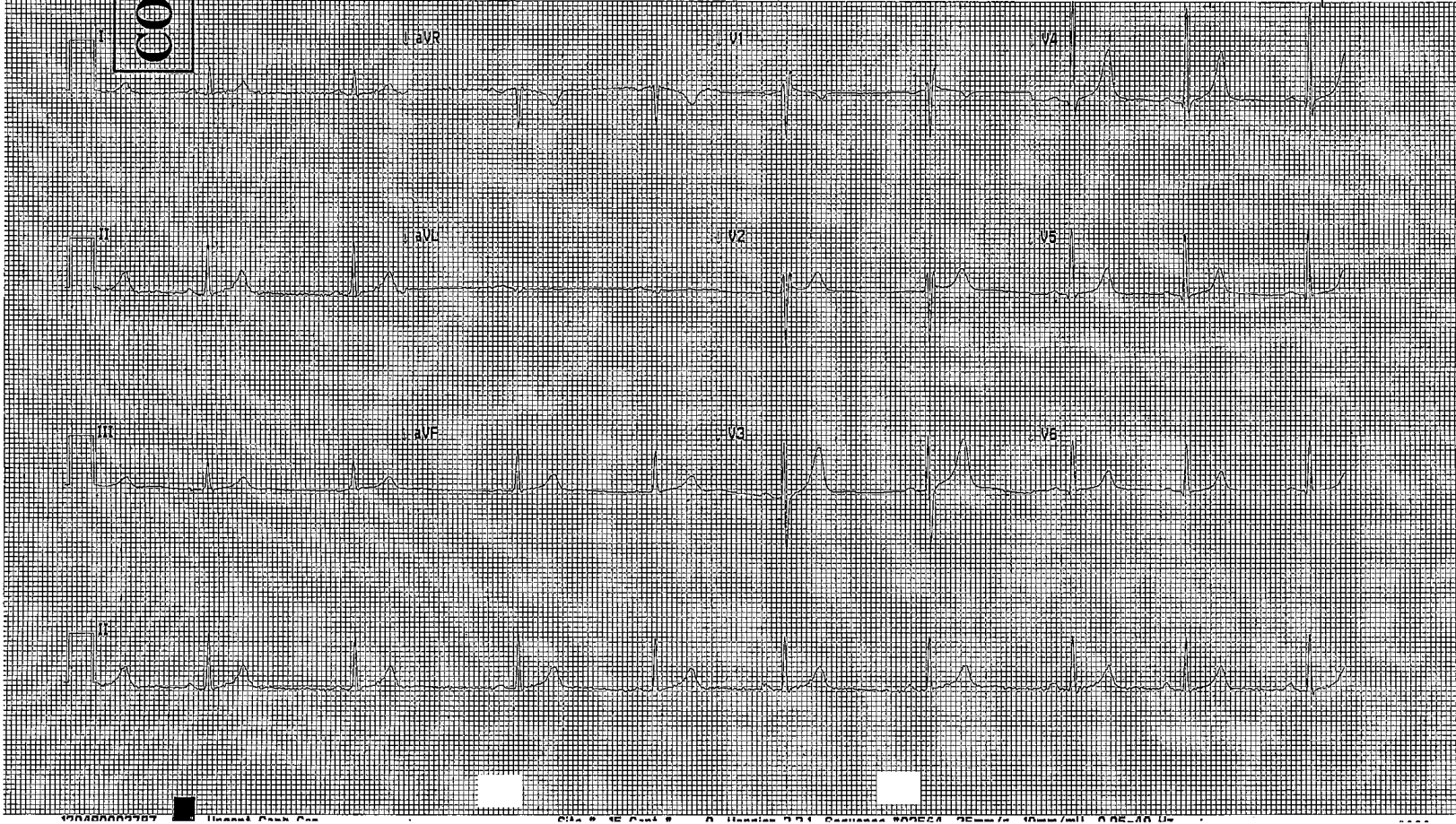
Vent-rate 54 BPM
PR int 160 ms
QRS dur 98 ms
QT/QTc 408/394 ms
P-R-T axes 44 66 64

SINUS BRADYCARDIA WITH SINUS ARRHYTHMIA
POSSIBLE RIGHT VENTRICULAR CONDUCTION DELAY (RSR (QR) IN V1/V2)
BORDERLINE ECG

UNCONFIRMED REPORT

?LWH unchanged w/ly
?RBBB from previous ECG

COPY



Mission: 20240521125510 Time: 14:02
Mission start: 21.05.2024 UTC+01:00

Patient: GARY SCUMSHAW
Case No.:
Age: 30/11/77 (M) (L44)
Weight:

HR: 61/min
CO: 5.0 L/min
SpO2: 98%

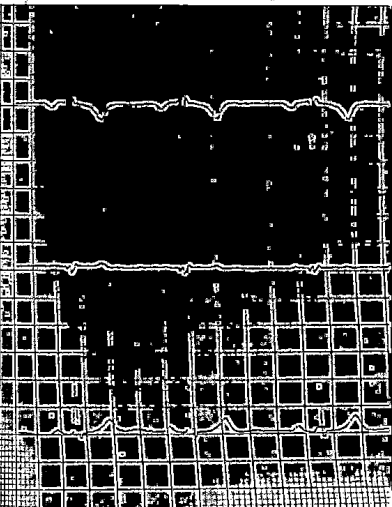
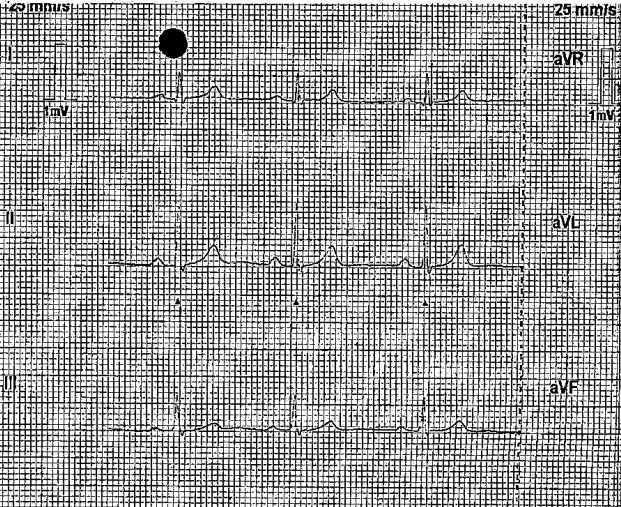
NBP: 139/79(99)? mmHg
RR: /min
PR: 66/min

Device: 0002447
Radio:
Medical team:
Call back phone: 07920271633

EKG filter: 0.05-40 Hz Mains filter: 50 Hz

Page 1 REL-313 C3 BP Page 2

ECG FILTER ACTIVE - INTERFERABLE! MAY BE AFFECTED



COPY

25 mm/s

25 mm/s

V1

V4

1mV

1mV

V2

V5

V3




V6

REL-3113-C3-BP

Page 4

REL-3113-C3-BP

Page 5

211 CE 0044 For use with  P/N 04121 D787 For use with  P/N 04121 For use with  P/N 04121



COPY

50 mm/s

0.5mV

25 mm/s

1mV

Page 6

aVR

V1

V4

aVL

V2


V5

aVF

V3


V6

REL 313 C3 BP

For use with  P/N 04121

P/N 04121

© 0014

For use with  P/N 04121

P/N 04121

D787

For use with  P/N 04121

P/N 04121

For use with  P/N 04121

P/N 04121



HR 92 bpm, PR 216 ms, QT 388 ms, QTc 383 ms, QTd 199 ms
 P-R-T axis: P 0°, R 115°, T 115°
 M: top in JN
 R: loss of R, reduction in AVI
 K: all R in JN
 Q: no dispersion
 S: no dispersion
 ST: 10 ms max, 28 ms from J
 T: 10 ms max, 28 ms from J

SEEG-IC FINDINGS
 Noise: 0.1V, small
 RMS: 20, 9, 5, 3, 4, 4
 Int. leads: 9, 9, 5, 5, 5, 5
 C: leads: 9, 9, 5, 5, 5, 5
 M: top in JN
 R: loss of R, reduction in AVI
 K: all R in JN
 Q: no dispersion
 S: no dispersion
 ST: 10 ms max, 28 ms from J
 T: 10 ms max, 28 ms from J

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

COPY

END OF PRINTOUT

NEWS key

1	2	3
---	---	---

FULL NAME: Gary Scrimshaw
 DATE OF BIRTH: 30/11/1979

DATE 21/5 21/5
 TIME 15:00 15:05

COPY

A+B Respirations Breaths/min	≥25		
	21-24		
	18-20		
	15-17	16	16
	12-14		
	9-11		
≤8			

A+B SpO ₂ Scale 1 Oxygen saturation (%)	≥96	97	98
	94-95		
	92-93		
	≤91		

SpO₂ Scale 2† Oxygen saturation (%)	≥97 on O ₂		
	95-96 on O ₂		
	93-94 on O ₂		
	≥93 on air		
	88-92		
Tick if using Scale 2 <input type="checkbox"/>	86-87		
Unplugged	84-85		
† Use Scale 2 under the supervision of a qualified clinician	≤83%		

Air or oxygen?	A=Air	0	0
	O ₂ L/min		
	Device		

NEWS Score for NEWS onset of confusion (no score if chronic)	≥220		
	201-219		
	181-200	2	2
	161-180		
	141-160		
	121-140	120	131
	111-120		
	101-110		
	91-100		
	81-90		
	71-80		
	61-70	71	82
	51-60		
	≤50		

Pulse Beats/min	≥131		
	121-130		
	111-120		
	101-110		
	91-100		
	81-90		
	71-80		
	61-70		
	51-60	52	54
	41-50		
31-40			
≤30			

D Consciousness Score for NEWS onset of confusion (no score if chronic)	Alert	✓	✓
	Confusion		
	V		
	P		
	U		

E Temperature °C	≥39.1°		
	38.1-39.0°		
	37.1-38.0°		
	36.1-37.0°	36.3	36.3
	35.1-36.0°		
≤35.0°			

NEWS TOTAL 0 0

Monitoring frequency 4hr 4hr

Escalation of care Y/N N N

Blood Sugar / /

Pain Score 0-3 / /

Initials R V A T O W A

SCRIMSHAW, Gary
 40 Johnston Crescent
 Tiffincoutry
 Clackmannanshire
 FK13 6PZ
 NEW
 8237397

National Early Warning Score (NEWS2)



Name: 3011795258 30/11/1979 M
 SCRIMSHAW, Gary
 40 Johnston Crescent
DOB: Tillicoultry
 Clackmannanshire
CHI No: FK13 6PZ
Address:

*** Regardless of NEWS always escalate if concerned about a patient's condition**

Total NEWS	Frequency of Monitoring	Clinical Response
0*	Minimum 12 hourly	<ul style="list-style-type: none"> Continue routine NEWS monitoring with every set of observations
1 - 4*	Minimum 4 - 6 hourly	<ul style="list-style-type: none"> Inform registered nurse who must assess the patient Registered Nurse to decide if increased frequency of monitoring and / or escalation of clinical care is required
5 - 6* or 3 in one Parameter	Increased frequency to a minimum of 1 hourly	<ul style="list-style-type: none"> Registered nurse to urgently inform the medical team caring for the patient Urgent assessment by a clinician with core competencies to assess acutely ill patients Ensure structured Response Stickers A & B are completed (<i>Not Applicable in Emergency Dept</i>)
7* or more	Continuous monitoring of vital signs (3 lead ECG and continuous SpO2 monitoring, 15 minute BP cycling - document observations every 30 minutes)	<ul style="list-style-type: none"> Registered nurse to immediately inform the medical team caring for the patient Emergency assessment by clinical team with core competencies to assess acutely unwell patients Ensure structured Response Stickers A & B are completed (<i>Not Applicable in Emergency Dept</i>) Consider transfer of clinical care to ITU

Exclusion Criteria

Anaesthesia and/or sedation may result in reduced conscious levels for a period of time. Scores that are increasing post-procedure and those including "P" or "U" always require escalation. The post-procedure NEWS score and post procedure plan that will include the frequency of observations should be communicated to the ward staff on transfer/handover of the patient.

Target O2 Saturation

Target SpO2 for most patients should be 94-98%. Selected patients may require target SpO2 88-92% (Appropriate in specific patients with severe chronic respiratory disease who either have established chronic Type 2 respiratory failure, or are felt to be at significantly increased risk of CO2 retention from oxygen therapy). These patients should use the modified (chronic hypercapnia) EWS. Arterial blood gases should be repeated at 30-60 min to check for rising CO2 or H+ after initiation of oxygen in this context.

Acute Respiratory Failure is a life threatening emergency

Severe Hypoxia (Requiring >60% O2 to maintain target SpO2)

Acute Hypercapnia (pCO2 >6 and H+ >45)

Urgent ST3 (or equivalent) review is required to optimise management.

Duty or on call consultant should be contacted if advice required.

Critical care referral and ventilatory support may be needed.

Codes For Recording Oxygen Delivery On NEWS Chart

A = Air (not requiring oxygen or weaning or on PRN oxygen)

N = Nasal Canulae

SM = Simple Mask

V24 = Venturi 24% V28 = Venturi 28% V35 = Venturi 35% V40 = Venturi 40% V60 = Venturi 60%

H28 = Humidified oxygen at 28% (also H35, H40 & H60 = Humidified Oxygen at 35%, 40%, & 60%)

RM = Reservoir Mask

TM = Tracheostomy Mask

CP = Patient on CPAP System

NIV = Patient on NIV System

OTH = Other Device: _____ (specify which)

Pain Score
0 = no pain
1 = mild pain
2 = moderate pain
3 = severe pain

Sepsis Screening Tool

Patient triggering NEWS ≥ 5 OR Clinical Concern
Neutropenia suspected OR MEWS triggering for obstetric patients

COPY

Is this likely to be due to infection?

Cough/sputum
Abdominal pain/distension/diarrhoea
Line infection
Endocarditis

Dysuria
Cellulitis
Headache with neck stiffness
Wound infection

Obstetric patients (Refer to FV protocol: Sepsis in Maternity Patients)
Perineal trauma Vaginal discharge Prolonged SRM Sore Throat

YES

NO

Escalate to Doctor/ANP with
"suspected sepsis"
Place Sepsis 6 sticker in notes
Prepare giving set/IV fluids

Escalate to Doctor/ANP
Repeat NEWS/MEWS in max 60 mins

ASSESS FOR OTHER CAUSES OF TRIGGERING

Two people work together to deliver the Sepsis 6 within 60 mins of patient first triggering

- Correct Hypoxia
- Take Blood Cultures
- Give IV antibiotics according to NHS FV Protocol

- Measure whole blood Lactate
- Assess urine output (catheter if obstetric patient)
- Start IV fluids - 20ml/kg, minimum 500mls in the first hour

ASSESS FOR SEVERE SEPSIS

SEVERE SEPSIS

Sepsis with \geq organ dysfunction:

- Hypotension
- Renal
- Respiratory
- Hepatic
- Hematologic
- CNS
- Metabolic acidosis

IF SEVERE SEPSIS

Contact middle grade Doctor (Consultant if obstetric patient)

Catheter mandatory if evidence of AKI

NO EVIDENCE OF SEVERE SEPSIS

Assess response to sepsis 6
Continue regular NEWS

SEPTIC SHOCK

- Hypotension despite fluid resuscitation
- Organ dysfunction

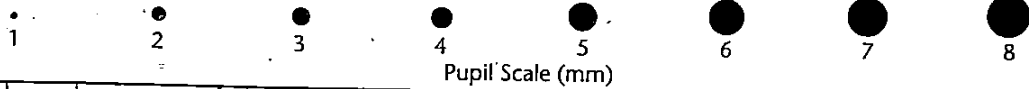
HIGH RISK FACTORS

- Hypotension
- Lactate > 4
- Unexplained INR > 1.5
- APTT > 60 secs
- Bilirubin > 34 (70 if obstetric)
- Platelets < 100

Conscious Level Chart (only as required for head injury observation)

DATE:														DATE:		
TIME:														TIME:		
COMA SCALE	Eyes Open	Spontaneously	4													Eyes closed by swelling = C
		To speech	3													
		To pain	2													
		None	1													
	Best verbal response	Orientated	5													Endotracheal tube or tracheostomy = T
		Confused	4													
		Inappropriate words	3													
		Incomprehensible sounds	2													
		None	1													
	Best motor response	Obey commands	6													Usually record the best arm response
		Localise pain	5													
		Withdraws to pain	4													
		Flexion to pain	3													
		Extension to pain	2													
		None	1													

COPY



PUPILS	right	Size													+ reacts - no reaction c. eye closed
		Reaction													
	left	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													
		Extension													
No response															

Pain Assessment & Management Guidelines

Pain Score:

- 0 = No pain
- 1 = No pain at rest
- 2 = Slight pain on movement
- 3 = Intermittent pain at rest
- 4 = Moderate pain on movement
- 5 = Continuous pain at rest

For Acute and Chronic Pain:
 For mild (1), moderate (2) or severe (3) pain refer to Pain Management Guidelines Forth Valley Formulary Appendix 27 & 28. Implement Pain Assessment Chart

For Cancer Related Pain:
 For mild (1), moderate (2) or severe (3) pain score, refer Palliative Guidelines.

Supportive and Palliative Care Indicators Tool (SPICT™)

COPY

Review Date: 2025

The SPICT™ is a guide to identifying people at risk of deteriorating and dying. Assessment of unmet supportive and palliative care needs may be appropriate.

Look for two or more general indicators of deteriorating health.

- Performance status poor or deteriorating, with limited reversibility. (needs help with personal care, in bed or chair for 50% or more of the day).
- Two or more unplanned hospital admissions in the past 6 months.
- Weight loss (5 - 10%) over the past 3 - 6 months and/or body mass index < 20.
- Persistent, troublesome symptoms despite optimal treatment of any underlying condition(s).
- Lives in a nursing care home or NHS continuing care unit, or needs care to remain at home.
- Patient requests supportive and palliative care, or treatment withdrawal.

Look for any clinical indicators of advanced conditions

Cancer

Functional ability deteriorating due to progressive metastatic cancer.

Too frail for oncology treatment or treatment is for symptom control.

Dementia / frailty

Unable to dress, walk or eat without help.

Choosing to eat and drink less; difficulty maintaining nutrition.

Urinary and faecal incontinence.

No longer able to communicate using verbal language; little social interaction.

Fractured femur; multiple falls.

Recurrent febrile episodes or infections; aspiration pneumonia.

Neurological disease

Progressive deterioration in physical and/or cognitive function despite optimal therapy.

Speech problems with increasing difficulty communicating and/or progressive dysphagia.

Recurrent aspiration pneumonia; breathless or respiratory failure.

Heart / vascular disease

NYHA Class III/IV heart failure, or extensive, untreatable coronary artery disease with:

- breathlessness or chest pain at rest or on minimal exertion.

Severe, inoperable peripheral vascular disease.

Respiratory disease

Severe chronic lung disease with:

- breathlessness at rest or on minimal exertion between exacerbations.

Needs long term oxygen therapy.

Has needed ventilation for respiratory failure or ventilation is contraindicated

Kidney disease

Stage 4 or 5 chronic kidney disease (eGFR < 30ml/min) with deteriorating health.

Kidney failure complicating other life limiting conditions or treatments.

Stopping dialysis.

Liver disease

Advanced cirrhosis with one or more complications in past year:

- diuretic resistant ascites
- hepatic encephalopathy
- hepatorenal syndrome
- bacterial peritonitis
- recurrent variceal bleeds

Liver transplant is contraindicated.

Assess and plan supportive & palliative care

- Review current treatment and medication so the patient receives optimal care.
- Consider referral for specialist assessment if symptoms or needs are complex and difficult to manage.
- Agree current and future care goals/plan with the patient and family.
- Plan ahead if the patient is at risk of loss of capacity.
- Handover: care plan, agreed levels of intervention, CPR status.
- Coordinate care (eg. with a primary care register).

Re-order Ref: TF/1013/SS

NEWS2

Ophthalmology Department
Consultant: J. Angus Scott
Tel: 01786 434000 Ext.4637
Fax:

Stirling Royal Infirmary
Livilands
Stirling
FK8 2AU

COPY

Ref: RI/RR/S237397
CHI: 3011795258

Clinic Date: 30 August 2010
Date: 07 September 2010

Dr Andreas Kolle
Tillicoultry Medical Practice
Park Street
Tillicoultry
FK13 6AG

Dear Dr Kolle

GARY SCRIMSHAW 30/11/1979
22/4 HILL STREET TILlicoulTRY CLACKMANANSHIRE FK13 6HF

I reviewed this gentleman today who had an acute right painful eye last week. His conjunctival swabs came to be negative today.

On examination today his right visual acuity was 6/12 improved to 6/9 with pinhole. Left visual acuity was 6/6. He has a right small healing corneal abrasion with otherwise unremarkable inferior and posterior segments. In addition there is no relative afferent pupillary defect and colour vision was full in both eyes. I have advised him to continue using the Exocin eye drops for a further four days. I have discharged him from the clinic.

Yours sincerely

Dr Rehab Ismail
ST2 in Ophthalmology to
J Angus Scott
Consultant Ophthalmologist

PLEASE USE BLOCK CAPITALS EXCEPT FOR SIGNATURE

Referral/Notification of Patient to GMP

SECTION ONE: To Be Sent To GMP

To: Dr.

PCC 30/08/10 SKY

COPY

PATIENT'S DETAILS

SURNAME (Mr, Mrs, Miss, Ms) SCLEIMSHAW

OTHER NAME(S) GARY

ADDRESS FLAT 4, 22 HILL STREET, TILLCOUNTRY

POSTCODE FK13 6HF TEL. No.

PRESCRIPTION DETAILS FROM CURRENT SIGHT TEST-DATE:										Previous corrected V.A.	Date of Birth
	Uncorrected V	Sph	Cyl	Axis	Prism	Base	VA	Add	Near VA	Date	
R											
L											

30.11.79

Specify Cycloplegic/Mydriatic if used.

POINTS REQUIRING ATTENTION - FOR INFORMATION (AND POSSIBLE REFERRAL):

This gentleman attended today with a very sore left eye. He says this started yesterday and his vision has dropped to about 20% today. He is also very photophobic. IOI's are R 22 L 25 mmtg @ 9.30 am today. I instilled proparacain but was unable to shine any light in his eye to determine the problem.

Optic discs

IOP R mmHg Tonometer used:
L mmHg Applanation/Tonometer

Visual Fields
R L

Plot attached ... Y/N

Name and Address of Optometrist/OMP
 MARY ROBERTSON
 OPTIC EYES
 105 HILL ST
 TILLCOUNTRY

Signed (Optometrist/OMP) Date 25.8.10

I agree / do not agree that any Ophthalmologist to whom I am referred for medical consultation and / or treatment may make information relevant to my eye condition and its treatment available to my Optometrist / Ophthalmic Medical Practitioner.

Sig Date

SECTION TWO: To Be Completed By General Medical Practitioner (if not accompanied by formal referral letter)

To: Dr. / Mr. / Mrs. / Miss / Ms _____

RELEVANT CLINICAL HISTORY - INCLUDE MEDICAL/FAMILY/OPHTHALMIC AND DETAILS OF MEDICATION:

Urgency Rating: Urgent/Soon/In turn

Blood Pressure: mmHg

Urinalysis:

Provisional Diagnosis:

Name and Address of GMP

Signed (GMP) Date

Part One - This part must accompany any referral and be retained by the Ophthalmologist

STIRLING ROYAL INFIRMARY
LIVILANDS
STIRLING
FK8 2AU

GASTROENTEROLOGY UNIT - Fax: 01786 434461



Consultant: Dr. Stuart Paterson
Consultant Physician - Gastroenterologist

Secretary: Julie McCormack - Tel: 01786 433661

Dr Peter Bramley
Dr Hugh Dalziel
Dr David Watts
Dr David Oliver
Dr Stuart Paterson
Associate Specialist: Dr Patrick Law

Patient Details:

MR GARRY SCRIMSHAW
7 MOSS ROAD,
TILlicOUNTRY,
CLACKMANNANSHIRE
FK13 6NS

G.P. Details

Dr BOLLAND
Health Centre 3
Hall Park ROAD
Sawhill
FK10 3JQ

Date: 26/08/10

Dear Doctor

Following this patient's recent hospital admission, the case notes have been reviewed together with the Immediate Discharge Summary. We consider the discharge summary to be accurate and please accept it as a complete and final summary of this patient's recent admission.

Any outstanding issues are listed below:

Discharge Date: 22/8/10

Follow Up Required: No Yes Arranged / To Be Arranged

Results Outstanding: Nil

Signed:

CVO

Page No:

096

*As per psychiatry
please copy d/c to
Dr Collins - Consultant
psychiatrist
Stirling Royal*



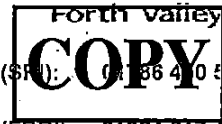
INVESTOR IN PEOPLE

Chairman Ian Mullen OBE BSc MRPharmS DL
Chief Executive Fiona Mackenzie MA(Hons) MBA CIHM DipISM

Forth Valley NHS Board is the common name for Forth Valley Health Board
Registered Office: Carseview House, Castle Business Park, Stirling, FK9 4SU

www.nhsforthvalley.com

Immediate Discharge Letter



Hospital: Stirling Royal Infirmary

Tel (SRI): 01786 434 000
 Tel (FVRH): 01324 566 000
 Tel (FDRI): 01324 624 000

Fax (SRI): 01786 430 588
 Fax (FDRI): 01324 617 421
 SRI - Ward 1

Consultant: Paterson, Dr Stuart
 Specialty: General Medicine

Discharging Ward:

GP Details		Patient Details		Admission Details	
Practice Code:	25031	Patient CHI No:	3011795258	Admission Date:	20/08/2010
GP Name:	Dr David S Borland	Patient Hospital No:	S237397	Admission Type:	Emergency - Injury - Self Inflicted (Injury or Poisoning)
Address:	Health Centre Practice 3, Hallpark Road, Sauchie, K10 3JQ	Surname:	Scrimshaw	Presenting Complaint:	Overdose and Poisoning
		Forename:	Garry	Discharge Date:	22/08/2010
		Date of Birth:	30/11/1979	Discharge To:	Private Residence - Living Alone
		Address:	7 Moss Road,, Tillicoultry,, Clackmannanshire, FK13 6NS		

Diagnosis/Problem List

Xa6Dd - Intentional amitriptyline overdose

Additional comment (Progress, Investigations, Procedures, Complications etc)

Admitted to ITU after being found face down on floor unconscious. Empty blister packs in the immediate area suggested mixed overdose. Intubated in ITU overnight due to reduced conscious level. Central line and arterial line inserted for supportive treatment and monitoring.

Paracetamol level - 236
 Salicylate - undetected
 Routine bloods - U&E, LFT, FBC all normal. Coag normal

Treated with IV parvolex. Extubated the morning after admission and transferred to the ward later that day. Seen by psychiatric SHO on call - no ongoing suicidal ideation. They will arrange urgent follow up with Dr Collins..

Plan: allow home. No medications.


Procedure	Performed	Time
Mechanical ventilation	20/08/2010	

Results Outstanding (Y/N) If yes, give details:	No
--	----

Information to patient/carer (Y/N):	Patient: Yes Carer (if applicable): No
-------------------------------------	---

Follow up arrangements

There are no Reviews planned

Authorisor's name: L Fabisiak	Doctor's Signature: 
Authorisor's grade: Advanced Nurse Practitioner	
Lead/Approved by:	
Date: 22/08/2010	COPY
Discharge Ward Nurse: Murphy, John	

Validation/Contact Name: Paterson, Dr Stuart

Name: Mr Garry Scrimshaw

THIS IS THE FINAL DOCUMENT
CHI: 3011795258

Forth Valley Acute Hospitals Acute Division
Medications Discharge Summary

Name:	Mr Garry Scrimshaw	Patient's Tel No:	COPY
Address:	7 Moss Road,, Tillicoultry,, Clackmannanshire, FK13 6NS	Patient's Tel Eve:	
Admission Date:	20/08/2010	Discharge Date:	22/08/2010

PATIENT ALERTS

Alert Group	Alert	Alert Comment	When Added	Added By
-------------	-------	---------------	------------	----------

PATIENT DRUG REACTIONS

CURRENT PRESCRIPTION (all medicines currently prescribed) **e.g. clinical indication for prescription monitoring*

MEDICINES DISCONTINUED

Nurse check on discharge:

Signature 1:

Name: Mr Garry Scrimshaw

Signature 2:

CHI: 3011795258

OPHTHALMOLOGY DEPARTMENT

Consultants: Dr J A Scott (Lead Clinician)
Dr J D Huggan
Dr T Saboor
Dr J Gillen

Stirling Royal Infirmary
Livilands
Stirling
FK8 2AU
Tel: (01786) 434000
www.show.scot.nhs.uk/nhsfv

COPY

AR/JP/ S237397
CHI No: 3011795258

24th November 2006

Dr Borland
Health Centre
Marshall
Alloa
FK10 1AB

Dear Dr Borland

Gary Scrimshaw (30.11.79) 43 East Castle Street Alloa

This patient had left corneal micro-perforation about 4 weeks ago. He has attended the clinic several times since then. He failed to attend today and also on the 17th November.

When last seen there was a small corneal scar affecting his left eye. Visual acuity was 6/6 and he was still on Exocin drops and Viscotears gel drops twice a day to the left eye. Presumably his symptoms have now resolved. I have therefore discharged him. No further treatment is required. If there is a further problem please refer him again.

Yours sincerely

A Ramsay
Locum Staff Grade in Ophthalmology

Accident and Emergency Department Stirling Royal Infirmary



3011795258

A&E No. 10047281

COPY

Surname	SCRIMSHAW	Forename	GARY	Title:
Address:	7 MOSS ROAD	Postcode	FK3 0AJ	
	TILlicOUNTRY CLACKMANNANSHIRE	Telephone:		
Date of Birth:	30.11.79	Sex:	M	Age: 30 yrs

GP Name:	KOLLE ANDREAS			
Address:	TILlicOUNTRY MEDICA... PARK STREET TILlicOUNTRY	Postcode:	FK13 6AG	
		Telephone:	01259 750531 <i>07935 630569</i>	

Next of Kin	TRACEY SCRIMSHAW			
Relationship:				
Address:	FLAT 4, 22 HILL STREET	Postcode	FK13 6HF	
	TILlicOUNTRY CLACKMANNANSHIRE	Telephone:	01259 750531 <i>0754 6967107</i>	
Manual CHI Entry:				

Date of Attendance: 20:08.10 13:37
 Date of Incident:
 Presenting Complaint: UNCONCIOUS

Triage	Tetanus Cover:
	Allergies:
P=	BP= / RR= Sat= BM=
PF=	GCS=E: M: V: Total:

Drugs Prescribed

Date	Drug	Dose	Route	Signature	Given By	Time

20/8/10

Clinical Notes

3011795258
SCRIMSHAW
GARY
30/11/1979

M

Seen by:

KAVANAGH

DATE:

SIGNATURE:

COPY

Found collapsed face down
in room.

Seen c 0900h → Shop →
Back to bedroom in B+B

Screened found him c
Called 999.

SAB - ↓ L.O.C.

tobacamy quadal amox

BM 4.4

Give naloxone foam

NOT DRUG USER

NO DRUG PATTERNS

o/a

A - tobacamy quadal.

B - ac 12 = L

C - Bp 150/88

1UA x2 + ac - blood

IVF ✓

D - ECS 3/15

but starting to Sigh

Swallow + some spit

Mumb.

BM - 9.6

Plan - ECG - QRS 118 → border ✓

Sommet Na bic IV ✓

IV fluids ✓

Might bleed posturing ✓

ABE - HT 42.6 + rest n

Guidelines Used:

Neuro-ex - tone n / reflexes n

slight ...

Date: 20/8/10

Clinical Notes

Patient Name:		3011795252 SCRIMSHAW GARY 30/11/1979 DATE: TIME:
Machinton 14 ⁰⁵		COPY
Remains GCS 3		SIGNATURE:
Self ventilating		
SaO ₂ 97%		
HR 122		
Given history likely TCA OD		
I think he needs RSI + ventilation		
Anaesthetics called		
RSI by anaesthetic ST3.		
w/ventil		
→ ITV		

IV Cannula:

Inserted by: _____ Time: _____
 Size/Colour: grey/green Batch No: _____

Site: Left + Right

COPY

Pressure Area Assessment / Mobility:

Absolute Risk (Score 2)

Unconsciousness
 Dehydration
 Paralysis

Relative Risk (Score 1)

Age over 70
 Restricted Mobility
 Incontinence

Pronounced Emaciation
 Redness over bony areas

Trolley

Chair

Mobile

Pain Score: 0 / 10

Analgesia Given? Y (N)

Own Meds? Y (N)

Name Band (Y) N

Investigations

FBC
U&Es
LFU
PARACETAMOL

GLU
CRP
AMY

CLOTTING
 G&S
 ESR

TROP
 D DIMER
 ABG

SALICYLATE

URINALYSIS
 HCG
 CATHETER
 ETHANOL

XRAY
 CXR
 AXR
ECG
 CULTURES

Troponin 0hr result:

Troponin 12hr due:

*Gary Schimshaw
 30/11/19*

Relative/Carer Informed ? YES NO
 Present YES NO

AMT 4

- How old are you?
- What is your date of birth?
- What is this place?
- What year is it?

If score is 3 or less proceed to Delirium screen

		Box 1	
I	Acute Onset and fluctuating course a) Acute change in baselines?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	b) Did the (abnormal) behaviour fluctuate	<input type="checkbox"/> Yes	<input type="checkbox"/> No
II	Inattention e.g. difficulty focusing attention, easily distractible	<input type="checkbox"/> Yes	<input type="checkbox"/> No
		Box 2	
III	Disorganised Thinking (box 2) e.g. disorganised thinking or incoherent speech such as rambling or irrelevant conversation, unclear or illogical flow of ideas	<input type="checkbox"/> Yes	<input type="checkbox"/> No
IV	Alternative Level of Consciousness (box 2) E.g. Alert, drowsy	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If all items in Box 1 are checked and at least one item in Box 2 is checked a diagnosis of delirium is suggested.

CLINICAL NOTES

CHI: 3011795258
 SCRIMSHAW
 GARY
 7 MOSS ROAD
 TILLCOLTRY
 FK13 6NS

Label
 Hospital No.
 ex
 of B.

COPY
 Ward Dept.

Consultant

Date: 20/8/10 1515.

ICU ADMISSION - ST3 FRASER - REMOVED FROM.

300⁺ ADMITTED ARE RESUS @ 1330

NO FIXED ABODE - LIVES IN BTB/SHELTER

FOUND FACE DOWN ON FLOOR, UNCONSCIOUS, SURROUNDED BY EMPTY TABLET PACKS.

NOT KNOWN TO ABUSE DRUGS, NO DRUG PALMPHALLIA NEARBY.

ONLY PRESCRIBED MEDS ARE

- ① AMULUPIRINE
- ② DICLOFENAC
- ③ PARALGAMOL

UNUSUAL QUANTITIES INCREASED.

DOES NOT SMELL OF ALCOHOL.

GCS 3 ON ARRIVAL, MAINTAINING OWN AIRWAY IN @ LATERAL POSITION C GUESS AIRWAY + ORAL AIRWAY

GIVEN SODIUM BICARBONATE 50ml 8.4%. ALTHOUGH NOT ALKALOTIC. NO RESPONSE TO 400mg NITROXONE.

MODIFIED RSI BY MYSELF FOR AIRWAY PROTECTION.

1mg ALFENTANIL, 50mg PROPOFOL, 100mg SIXAMETHASONE

GRADE I LARYNX, SIZE 8-0 EST

SUCCESSFUL → NO CONTAMINATION. UNCOMPLICATED.

HYDROXYL 50mg + 40mg TO FACILITATE VENTILATION AND TRANSFER. PROPOFOL 1% @ 10ml/hr.

AIR LINE SIZED BY DR THOMAS - 1800S

TRANSFER ICU FULL MONITORING - UNBENEFICIAL

ate
A = SIZE 8.0 ENT, CLEAR ON SURFACED

COPY

B = PSIMU F_{O2} 0.5 15/S SIM PARAMS 4600X15

CHEST CLEAR

C = W/ROM + W/ROM PERFUSED

TACHYCARDIA - SIMS TACHY QRS 110 QTc 439

RATE ~ 115-140 1BP

UNSTABILIZED LW -

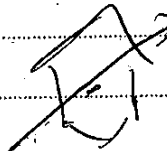
HAD 2000ML W FLUID IN VAC

HS L11140 -

D = GCS 3 PRE RSI

PUPUS SIZE 4, SUGGASH

BM 4.4 TEMP 35.6

 ABDOMEN SOFT
NAD

ECG: SIMS TACHY 140bpm QRS 110 QTc 439.

OTHERWISE NIL.

UNES = ART LINE 20/8/10 (2) KATANA

1KG VENFLOW (2) HANO

1KG VENFLOW (2) HANO

PLAN (1) VENT SIMOLE

(2) WAKE + WEAN AS TABLE

(3) ADD UK TO BLOODS

(4) MAP > 65 AND V/O > 60ml/h PLEASE

↳ GEORVUS / BACKGROUND FLUID.

CLINICAL NOTES

Write - imprint or Attach Label
tal No. _____
CHI: 3011795258 30/11/1979 M 3.
SCRIMSHAW
GARY
7 MOSS ROAD
TILLCOUNTRY
FK13 6NS

COPY

Consultant

Date

20/11/10
1515

- ⑤ HAST PARACETAMOL / SALICATE LEVELS
- ⑥ TITRATE BICARBONATE IF BECOMES ACIDOTIC
- ⑦ CKL FOR GT
- ⑧ REPEAT ECG IN 1 HOUR
- ⑨ UPDATE NEWS OF KEN

FRASER
STB 984

NOTE: RESPONSE CRI FROM HFE

↳ PARACETAMOL 236

↳ SALICATE UNOBTAINABLE

↳ FOR PARVOLEK.

FRASER
STB 984

20/11/10
1730

STB FRASER - LANDSPERAVE

DRAMATIC FALL IN BP TO 50/10, UNRESPONDING

HEART RHYTHM UNCHANGED.

Cont GIVEORINE + long METOPROLOLOL + ESCORTON OFF
BP SAWE UP TO 140/70 AGAIN.

Went 10% calcium gluconate plus RINGER SODIUM
(125ml/hr) Sodium Bicarbonate 1-207.

RLIS IN SEARCH - FRASER

US GUIDED - SEVERAL ATTEMPTS - WASTE

PROXIMITY TO CANNED BLOOD.

ACCESS AS PROBA

ALL LINES FUSION/ABP.

CKL - APPROPRIATE PLACEMENT

FRASER
STB
984

Date

20/8/10 Chad Conroy etc
1830

COPY

NUM ERCS
EKG + INTERV MYOCARDIUM
→ GACI
→ NCTHECS

Seary

20/8/10 S13 FURSC
2020 UP DRAGO EX WIFE
EX WIFE CONTINUED ABOUT GARAH

- RECENTLY MARRIED TO
- PLAYING "MIND GAMES"
- "IMAGINABLE THINGS"

KEEN THAT HE IS ASSESSED BY PSYCHIATRY.
HAVE REASSURED HER THAT WE WOULD KEEP AS
SUPPORTIVE.

Dr Burgess
S13 984

20/8/10 Stable overnight
19:50 Appraised.

and when well prepared.
No further episodes of CVS instability
overnight

RS Clear chest.
P-SINUS 218, O₂
Mach Soft: quiet
GU Adequate urine vols

CLINICAL NOTES

Write on this Label
Hospital No. _____
CHI 3011795258
CRN: S237397 30/11/1979 X
SCRIMSHAW GARRY M of B.
7 Moss Road,
TILLCOUNTRY,
Clackmannanshire
FK13 6NS

COPY

Consultant _____

Date

Plan - Stop sedation
- aim to wean / extubate
- Paracet infusion continues as prescribed.

WFL

21/8/10

1230

ST3 FRASER

SEVERAL ATTEMPTS MADE TO CONTACT URSULA PSYCH.
NO ANSWER TO TELEPHONE (MEDICAL TEAM)
SWITCHBOARD DON'T HAVE NUMBER FOR SPECIALIST
PSYCHIATRIC NURSE TEAM.

NO ANSWER AT USUAL NUMBER CONTAINED IN URSULA
PSYCH FOLDER.

PLEASE CAN WARD DOCTOR MAKE REFERRAL WITHIN
PATIENT TRANSFERRED?

MANY THANKS,

FRASER
ST3 984

21/8/10

1315

PATZISAL - MED REC CURS

- OD as above Amitriptyline + Para
- plan as above
- P to be transferred to medical
ward.

[Signature]

IV Cannula Insertion/Removal Record

Name: ARMY GUNSHAW Ward: 16
Inserted by: DONNA FRASER Date: 21/8/10
Size/Colour: 20G (PINK) Batch No: _____
Insertion Site: ① ARM
Removed by: _____ Date: _____

Date

Arrived safely from HDU

16:00 - Pt very unsteady on feet, requiring assistance x2 when mobilising

At high risk of falls.

Note to NOK state pt has not eaten since last Friday.

Tie cream taken at tea-time + 1/2 MINCE POTATOES

Wanting to go out for cigarette.

NOK state unable to access B&B to get pt's belongings. Pt quite anxious re same.

Unsettled overnight + slept very little. Obalising independently within ward + appeared more steady.

Appears vague + confused.

Didn't appear to know what time of day/night it is.

Wanting to get ready for work at 1 hour.

Also looking for his wife in the ward.

22.10.10

3:00pm. Went to bed + appeared to sleep for couple of hours. Dr. Stirling SA

COPY

Slip No. 15d

Against Advice

SURNAME (Block Letters)

FIRST NAME (Block Letters)

UNIT NUMBER

This is to certify that I am leaving this Hospital at my own request, at my own risk, and on my own responsibility, and against the advice of the Medical Staff.

Signature

Address

Date 22.8.10

AGAINST ADVICE (Patient)

STB044

◆ PROGRESS NOTES

CHI: 3011795258
 SCRIMSHAW
 Garry
 7 MOSS ROAD,
 TILlicOLTRY,
 FK13 6NS

30/11/1979

M
 It No. of B
COPY

Date and Time	
22/8/10	<p><u>Psych R/W</u></p> <p>Summary 35/100 impulsive overdose in context of social pressures. Denies suicidal intent. Remorseful. Thankful for treatment. No objective evidence of underlying mental illness. Denies suicidal ideation or thoughts of harm. No immediate psychiatric input required.</p> <p>Man happy for d/c when medically fit. Will arrange urgent OP for visit Dr Collins</p> <p>Please inform GP on discharge. Would suggest continued dispensing of amphetamine or d/c if to continue on discharge.</p> <p>Happy to r/w if required.</p> <p>(Will forward copy of full assessment to social conc in due course)</p> <p style="text-align: right;">Dunlop BOYO CTU</p>
12 ⁴⁵	<p>ACT RNP</p> <p>Much improved. Seen by Y as above. Does not wish to continue on amphetamine. Bloods normal. is</p> <p>Pain: chase today's coag</p> <p>(4) if normal with Phas above</p> <p style="text-align: right;">Platner</p>
13 ⁰⁰	<p>Coag normal. Home</p> <p style="text-align: right;">Rlein</p> <p style="text-align: right;">at 104 508</p>

5237397

DR HUDA

THURS 1PM

COPY

ACUTE OPHTHALMOLOGY TELEPHONE REFERRAL INFORMATION FORM
(CIRCLED FORCED CHOICE ENTRIES AS APPROPRIATE)

CALL TAKEN BY: Dr SIN GAOIN AT: SRI / FDRI
 DATE: 26/10/06 TIME: 10.05 am / pm
 FROM: Dr BOLELAND of SRI A&E / FDRI A&E / Ward
 GP Optician
 Other

PATIENT DETAILS
 Surname: SCRIMSHAW C/s no:
 Forename: CARY
 d.o.b. 30.11.79 Phone no: 01259
 Address (optional): 218581
 Previous Eye Clinic Contact: Yes / No
 If yes, under which Consultant: AC / DH / TS / AS / unknown
 (If yes, fix appointment with relevant Dr / clinic unless urgency dictates otherwise.)

REFERRING DIAGNOSIS / SYMPTOMS AND CURRENT Rx
 WED. 18/10/06
 SEEN @ SRI A&E CHLOR GIVEN ? CORNEAL
 VOLTAREL DROPS. ABRASION
 SKENAY GP TODAY EYE PAINFUL ON EXAM ?
 CORNEAL ULCER

APPOINTMENT WITH RECEIVING OPHTHALMOLOGIST
 To be seen by: Clinic SHO / Duty SHO / Dr
 To be seen at: SRI Clinic / SRI Ward 21 / FDRI
 Date: 26/10/06 Time: 1PM
 FAX OR SEND TO THE DOCTOR RECEIVING THIS PATIENT

Dr seeing patient at above time/place then enters next stage information:

RECEIVING OPHTHALMOLOGIST'S DIAGNOSIS AND Rx

Patient: Seen, Discharged / Seen, to be reviewed / Admitted / FTS
 Consultant advice sought - by phone / in person / No

COPY


ALLOA HEALTH CENTRE

*Dr D S Borland
Dr C B Lamb
Dr F Green
Dr G Riddle

Marshall
ALLOA
FK10 1AB
Telephone No: 01259-216701
Fax No: 01259-724790



RCGP Scotland
2003-2006

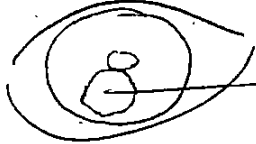

3011795258
Scrimshaw, Gary
30/11/1979 M
43 Eastcastle Street
ALLOA
55344 Dr Borland


26.10.06.

On-call ophthalmologist.

Dear Dr, many thanks for seeing
this man who was struck in the (L)
eye last wednesday by a nail. He
was seen in A&E & given chloramphenicol
ointment & ibuprofen drops.

Today his VA is only 6/18,
his eye is watering & uncomfortable.

A&E -  Corneal opacity &
staining.
? corneal abscess.

Regards,


Gary Scrumshaw

5237397

STIRLING ROYAL INFIRMARY

EYE NOTES

26/10/06
SN/FS

D.O.B 30/11/79

43 East castle STREET
A11A
COPY

Diagnosis: Penetrating Corneal injury

Allergy:

Vision: Rt eye

6/12 P/A 6/9

with out glasses

Lc eye

6/12 P/A 6/9

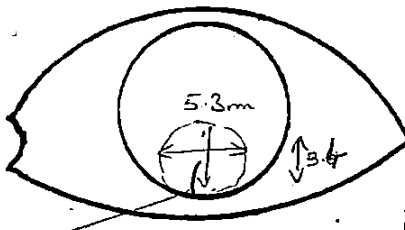
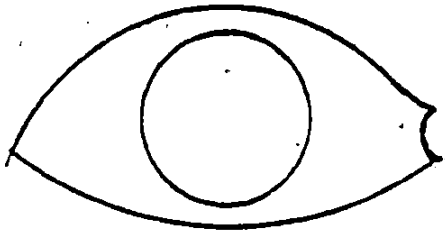
with glasses

Ext

Rc

has gls - not with h

Lc



R L

Pupils

AC

Tension

Cornea

Iris

Lens

Vitreous

Discs

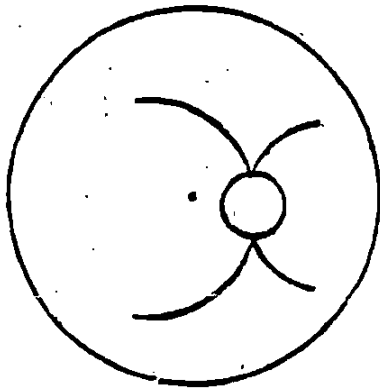
Vessels

Macula

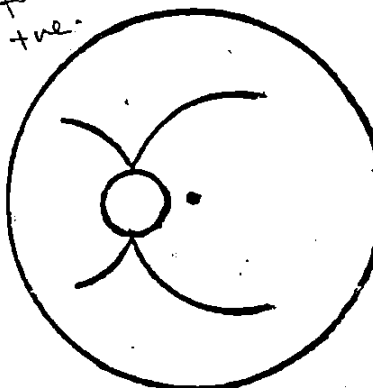
Ac quiet

2mm penetrating Corneal cut
Scidat +ve.

R



L



NaCl Fluor Washout ✓

Simplon 72 Plane

18.50 - 0 @ cl

Flare

inserted

KP

Synechiae

Angles

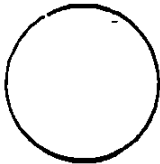
Others

Loose epith tissue

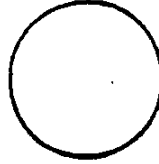
Slit Lamp:

Cornea
Lens

R



L



History: picky Slabs of wood when a pin stuck

Removed Treatment

eye white try to remove it
a week ago given AB drops & oint
at A/E eye still painful watery

D/W Dr. Saboor

admit

BCL 18mm

Exocanthion 1/2

Review tomorrow

R/L -
R/L -

R/L

Atropine

H.C.

Eucatropine

Phenylephrine

Mydrilate

Others

Scho

CLINICAL NOTES

Write - imprint or Attach Label
 Surname Scrimshaw Hospital No. 5237397
 Forenames GARY Sex M
 D. of B. 30/11/79
 Address 6 Broomfield West
Merstree
 Ward / Dept. **COPY**

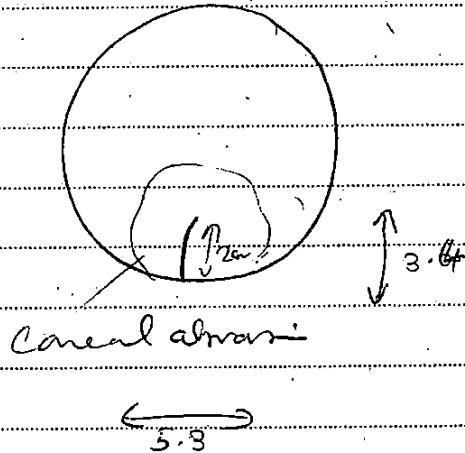
Consultant

Date

26.10.06

Inj to L eye while removing stable from wood slabs.
 one went to Eye. Ink duration
 Admitt

Ⓛ penetrating corneal wound.
 2mm long inf



D/W - Dr T.S.

BCL 18mm

Exocis hairy

Review Tomman in clinic.
 Dr. Tomman to see.
Jaha

26/10/06
 1633

JHO. CLERK - IN

PC: AS above

PMH: 1996: Thyroglossal Cyst Removal

1996: Appendicectomy

1996: Repair to cut thumb
 - tendons
 - nerves
 - soft tissues

740-0112 (cont'd)

COPY

HTx: None
NKDA

FAFICVA

SHTx: Live w/ wife
unemployed

Tetotal

Smoke <10/day

o/E: Systemically well.

Hands: Warm
No Stigmata

CVS: Pulse 72 (N)
Apex - undisplaced.
Jedema
HS I+II+III.

RESP: Expansion }
Percussion } R=L=(N)
Resonance }

~~AA~~

ABDO: ~~o~~ (SNT
o masses
o fluid
BSV Pulses ✓
o Hepat. ✓)

csc McCree
293

CLINICAL NOTES

Write label No. _____
 S: _____
 Fr: _____
 CHI: 3011795258
 CRN: SZ 237397 30/11/1979
 AC: SCRIMSHAW GARRY M
 43 EASTCASTLE STREET
 ALLOA FK10 1BB

COPY
 v. v. / Dept.

Consultant

Date

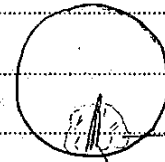
27/10/6
 KS

1/2 irritation ++ since insertion of lens -
 Not painful just very ~~bad~~ uncomfortable
 - worse than prior to insertion

DR lens in situ
 otecus
 pv cv mv *
 *

Vu 6/12
 CP 6/9

X ray orbits done
 when 1st seen in ALE
 on the day of injury
OFB seen



corneal abrasion
 corneal laceration
 ALE odd all
 ALE deep
 pupil round
 BCL in place (18mm)

pt 1/2 irritation ++
 since insertion of BCL.
 - 9 try smaller BCL

Precis: UV. 8:70:1445:00 p' (initially)
 cv
 mv

Hamon
 a/crown x by lun/day

re Monday p'chm

Am pcc

CLINICAL NOTES

Su
Fo
Ad

CHI: 3011795258
CRN: SZ 237397 30/11/1979
SCRIMSHAW GARRY M
43 EASTCASTLE STREET
ALLOA
FK10 1BB

tel
il No.

COPY
Ward / Dept.

Consultant

Date

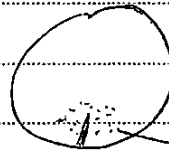
30/10/06
Lt. Rv \bar{c} gls = 6/6+3 Lv \bar{c} gls + CL = 6/6.

Pt was admitted to ward 29 B on Thurs 26/10
+ discharged Fri 27/10/06.

Attended SRI eye clinic Fri 27/10 and
had soft CL inserted.

(L) comfortable

RCL in place



epi micropts

Acc quiet

pupil round

Review Friday

3/11/06 - PCC eye

clinic
GP

CLINICAL NOTES

Write - imprint or Attach Label
 Surname SCRIMSHAW Hospital No. 23739
 Forenames GARY Sex M
43 EASTCASTLE STREET D. of B. 30/11/1979
 Address ALCOA

COPY
 Ward / Dept.

Consultant P.C.C CLINIC

Date

3/11/06
KG.

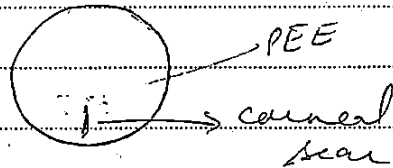
VR, 6/16

EPs

VL, 6/16

→ No notes available. perforation (micro)
 H/o. (L) Corneal ulcer. 26/10/06 (TS on call)
 folio treated E Bandage CL.

Unip G-Exocin Q10 (L-E)



BCL removed
 Seidel Negative

G. Exocin } TID R-E
 & Vitostear }

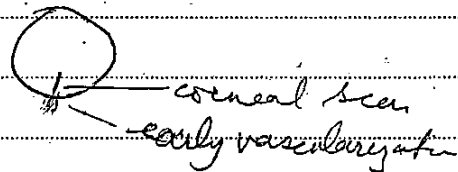
See 1/52 PCC.

10/11/06

RVA 6/5 pt

LVA 6/5

with GS



G. Exocin B.D } L-E
 Vitostear B.D }

1/52 P

CLINICAL NOTES

Sut CHI 3011795258 el
 For CRN: S237397 30/11/1979 I No.
 SCRIMSHAW GARRY M 30/11/79
 Flat 4, 22 Hill Street
 Ad TILLCOUNTRY, Clackmannanshire
 FK13 6HF
COPY
 Ward / Dept.

Consultant AR/JAS

Date
 25/8/00

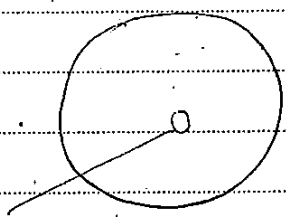
Optician referral with acute (R) red painful eye.

Medx Nil Allergy Nil Rxn Nil

UAC 8/36 u/a
 6/18 pH

UAC 6/9 u/a
 6/16 pH

Sticky sore R-E 2/7
 Blurred vision 2/7



A/S ✓

defect in Descemet's memb.?

Diffuse PEE

cells + AC

A

1/ Conjunctivae
 2/ AC activity?

14

✓ Disc ✓ viral

Plan: 1/ Conj swabs ← bacterial
 Chlamydia

Show to JAS
 Thank

2/ G. Exocin QID R-E 7 See 5/7

3/ Oct Viscotears QID R-E 8 Pcd

08/10

3:25 AM

SMD

RVA) 6/12

PI 6/9

GIS

LVH) 6/6

COPY

Munir Ahmad

PIV 9. (R) PEBs

any: small -ve

(R) visual problems -> glance at the dir

on 9 - EXO can

0.15

(2)

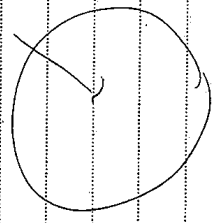
oKARD

(P)

(5)

Q1. 1. (R) full 19

(2) full 19



Radial
curved
abnorm

o cells AE JAD

13 14

CLINICAL NOTES



CHI:3011795258
CRN:S237397 30/11/1979
SCRIMSHAW GARRY
Flat 4, 22 Hill Street,
TILLCOUNTRY,
Clackmannanshire
FK13 6HF

abel
ital No.

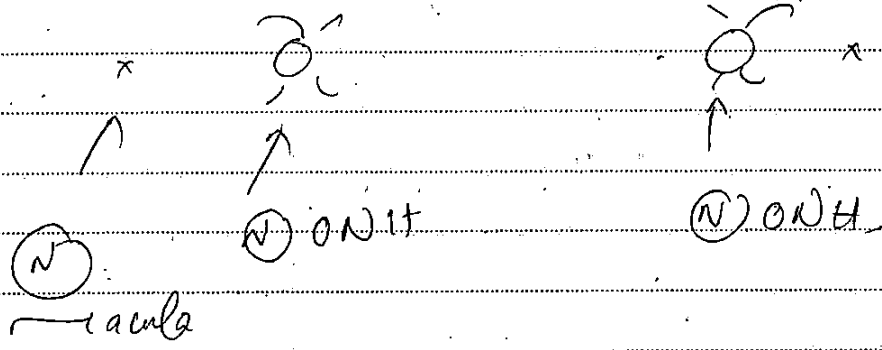
M B.

COPY
Ward / Dept.

Consultant

Date

30.8.10



Imp. • NOcular pathology

CT g. Exocin x 4A.

Dioctoy.


R kmar
ST2.

COPY

Date

Vent. rate 140 bpm
 PR interval 132 ms
 QRS duration 103 ms
 QT/QTc 288/439 ms
 P-R-T axes 55 74 32

Sinus tachycardia
 Camo. rule out Anterior infarct. age... confirmed
 Abnormal ECG

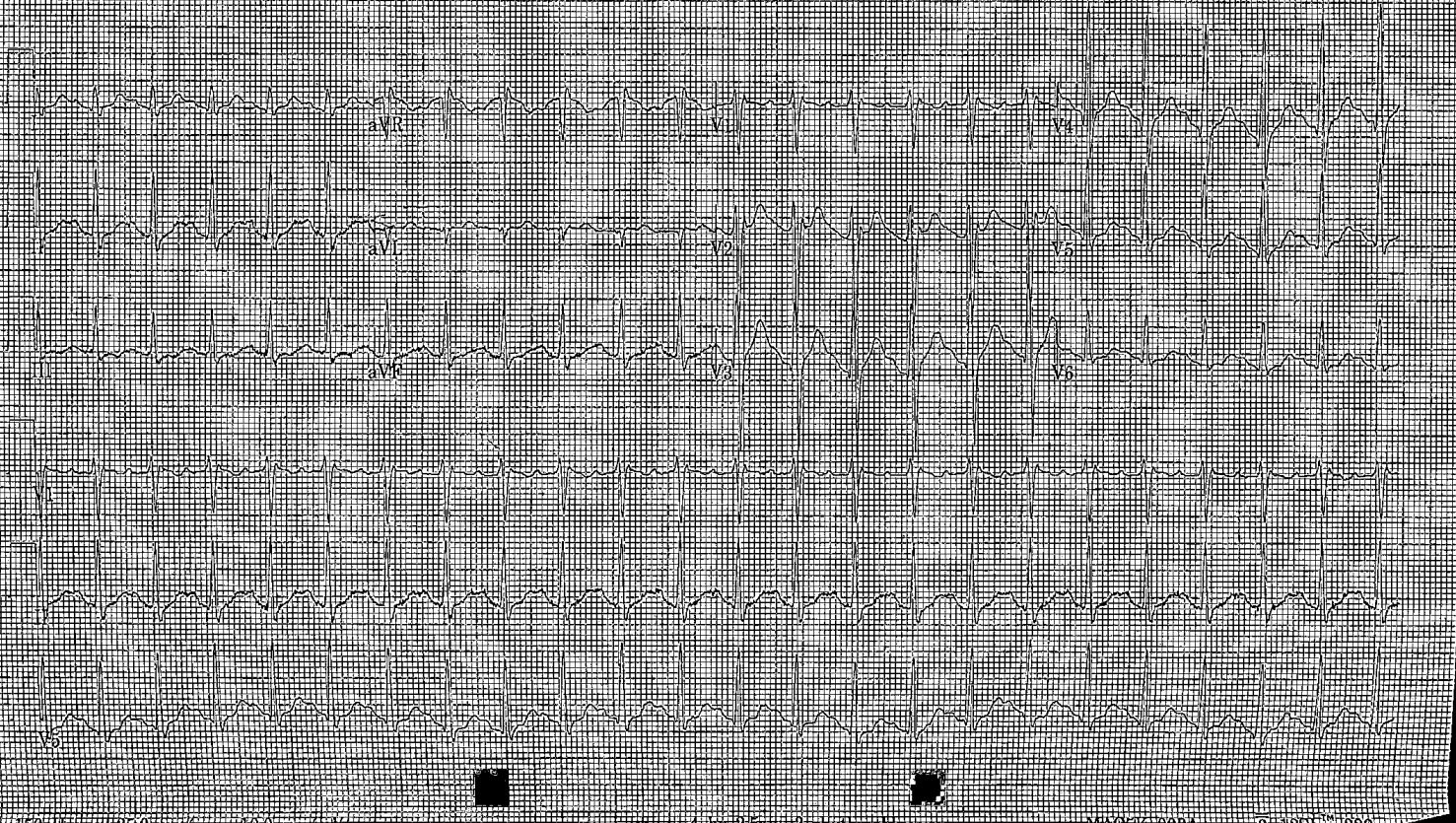

 CHI: 3011795258 30/11/1979 M
 SCRIMSHAW
 GARY
 7 MOSS ROAD
 TILLCOUNTRY
 FK13 6NS



Technician
 ...

Referred by

Unconfirmed



20-Aug-2010 18:43:0

CORONA CARE

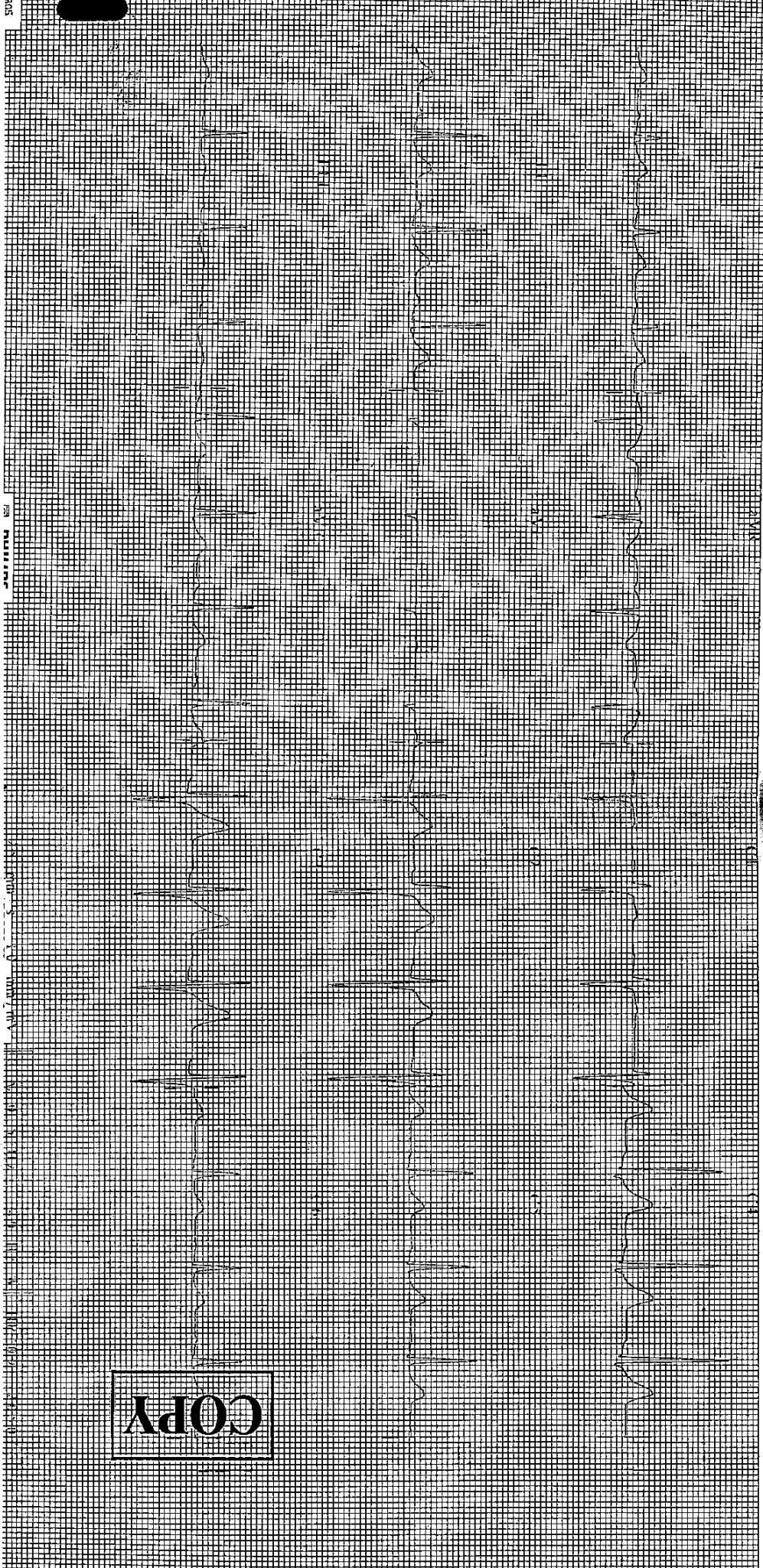
GARL SCINISAW

Rate 87 . AGE NOT ENTERED, ASSUMED TO BE 50 YEARS FOR PURPOSE OF ECG INTERPRETATION
PR 195 . NORMAL SINUS RHYTHM, RATE 87 . Normal P axis, PR, rate & rhythm
QRSD 90
QT 339
QTc 408

--Axis--
P 57
QRS 65
T 46

- NORMAL ECG

Unconfirmed diagnosis.



COPY



RADIOLOGY REPORT- Stirling Royal Infirmary

CHI NUMBER: 3011795258 Examination Number: 30701658

Name: Scrimshaw, Gary DOB: 30/11/1979

**Address: 22/4 HILL STREET, TILlicOUNTRY, CLACKMANANSHIRE, FK13
6HF --CC: -**

Examination: XR Chest

Examination Date: 20/08/2010 Examination Time: 18:20

Dictating Radiologist: DR PAUL KELLY

Typed by: None

Referring Consultant: MAIR W DR ANAESTHETIST

Referring Department / Location: STIRLING INTENSIVE CARE UNIT

Clinical history: Overdose with reduced coma scale and right IJ line inserted.

Findings: Portable supine film. Mediastinal and pulmonary contours consistent with this. Minor consolidation noted in right cardiophrenic angle. ET tube and right internal jugular line in satisfactory position.

Examination Date: 20/08/2010

Examination: XR Chest


Date Reported: 31/08/2010

Dictating Radiologist / Clinical Specialist By DR PAUL KELLY

Verified by: DR PAUL KELLY on 31/08/2010

COPY

MUST - Nutritional Risk Screening

Patient Details (or attach ID label)  Name: CHI: 3011795258 30/11/1979 M SCRIMSHAW D.O.B: Garry 7 MOSS ROAD, TILlicOUNTRY, Unit/Cl: FK13 6NS		Ward: ONE Date of Admission: 21.8.10 Normal weight: 10st 8 Source:
--	--	--

Step 1 BMI	Weight (kg)	Measured	Height (m)	Measured	BMI (see chart)	Step 1 Score (circle)
	67.25	Reported	5'4"	Reported	27	> 20 = 0 18.5-20 = 1 < 18.5 = 2
Step 2 Weight Loss over last 3-6 months	Wt Loss * (kg)	Measured	% Change (see chart)		Step 2 Score (circle)	
	3lb	Reported	< 5%		< 5% = 0 5-10% = 1 > 10% = 2	

* this refers to the total unplanned weight loss over the last 3 – 6 months

Step 3 Acute Disease Effect	Acute illness AND there has been, or is likely to be, no nutritional oral intake for 5 days Not NBM = score 0 NBM = score 2	Step 3 Score (circle) 0 2
Step 4 Overall Risk Score	Add scores from Steps 1 + 2 + 3 = Total	Total Score: 0
Step 5 Management	Develop and Implement appropriate Nutritional Care Plan	Nutritional Care Plan (circle) 0 = Low Risk 1 = Medium Risk 2+ = High Risk

Screening results reported to: L. Friel

Screening completed by: J. Reid Date: 22.8.10

Critical Care Unit

COPY

Date: 20/8/10	Day No: 1	D.O.B.	Surname
Date of Admission: 20/8/10	First Name: SCRIMSHAW GARRY M		CRN: S237397 30/11/1979
Diagnosis: OVERDOSE OF TRICICLIL ANTI DEPRESSANT + GCS.	Address: 7 Moss Road, TILLCOUNTRY, Clackmannanshire, FK13 6NS		30 yes
Critical Care Consultant: Dr MAIR.	Referring Consultant:		

Ventilator: GALLIED	Fluid Balance	
Date Ventilation started: O/A	Intake	Output
Date Ventilation finished:	Oral	Urine
E/T Tube Length at Lips: 22cm. <u>subglottic drain</u> <u>non-subglottic drain</u>		Gastric
Trachy - Inner tube change		Bowel/Stoma
Cuff Pressure: 8am 2pm 8pm 2am 6cm H ₂ O		Drain 1
NG Tube Length at Nose:		Drain 2
CVH Commenced		Drain 3
CVH Discontinued		Total in
MRSA status <i>Screened</i> Site:		Total out
Day Nurse		Previous 24 Hour Balance:
Urinalysis		Cummulative Balance:
Night Nurses: 00.00 - 08.00 20.00 - 08.00 <i>gm</i>	Daily Plan:-	

CVC Maintenance Bundle *NEW INSIDED TODAY* **12hrly Ventilation Screen**

Is CVC still required?	Y / N	D	N
If NO then remove & send tip for C&S. Aseptic technique for procedure.			Y
Is CVC dressing intact?	Y / N		Y
If NO or older than 7 days re-dress. Aseptic technique for procedure.			
Insertion site very inflamed or pus present?	Y / N		N
If YES seek advice, remove line, send tip for C&S. Aseptic technique for procedure.			
CVC Bungs insitu > 3 days?	Y / N		NEW
If YES change bungs & 3-way taps. Aseptic technique for procedure.			

Aseptic Technique =
 1. Level 2 hand wash
 2. Dressing pack & sterile gloves
 3. Chlorhexidine 2%

Reduce support using ventilation management Flow Chart
 Yes / No (see exclusions below)
 *Cooling
 *Head injury
 *Airway issue

Appropriate to switch off / reduce sedation? (see exclusions)	D	N
SaO ₂ (Target 94%)		Y
FiO ₂ < 0.35?		Y
Secretions manageable?		X
Adequate cough?		N
RSB Index < 100? (F+ Vt)		Y
PEEP ≤ 5?		X
Tube comp on?		Y
Haemoglobin > 70?		X

Sepsis Screen if temp > 38° (unless screened in last 48hrs)	Microbiology Results
Peripheral Blood Cultures:	
C.S.U.:	
E.T. Aspirate:	
Other Sites:	

Night Report:

COPY

Day Report:

- 1/ Ventilation - Continues on P-SIMV, FiO_2 + 35%, otherwise settings unchanged
 SpO_2 > 97%
 A/E available throughout all lung fields - minimal yield of mucopurulent secretions on suctioning
 ABG's on dated
- 2/ Cardiovascularly labile at times; x1 episode of hypotension; then had slow bolus of calcium gluconate, no inotropic support required at present
 HR 80-120 bpm, monitoring in sinus rhythm. (12 lead ECG completed)
- 3/ F & G/ RASS - 4/-5, on Propofol / Alphenesol. infusions in progress.
- 4/ N/G tube in situ - ? for total feed - km, stable
 Ferrelax infusion in progress, no RBC₂ infusion in progress
- 6/ Good diuresis
- 7/ J & S/ Renne. a/eo intact
- 8/ N/G new MRSA swab obtained
- 9/ Family into visit this evening

SEN M GILL
 M COCKSAY

Events

01.00		COPY	Initials
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	Transferred to ICU - Urinary catheter inserted		M
16.00	+ R 50/30, HC + 70; long epinephrine + long Metaraminol give		M
17.00	CL infection ✓		
18.00			
19.00	PRN care taken over.		
20.00	Safety checks ✓ admission ✓		R
21.00			
22.00	7AC → (L), FIO ₂ & EST, Present RR 6 13		R
23.00	ALL wounds + 17804 wounds		R
00.00			

	AM	PM		AM	PM
Admitting team aware Y / N			Does patient have a PVC Y / N (if N go to AB's)		
APACHE II score complete Y / N	NA	NA	New PVC today		
Wardwatcher up to date Y / N			Documentation/sticker completed Y / N		
Is patient ventilated Y / N (if N go to blood sugars)			Is PVC still required Y / N (if N then remove=R)		
HOB > 30° Y / N			Evidence of inflammation / erythema Y / N		
Sedation Holiday appropriate Y / N / LEx / NA			Dressing intact Y / N		
Ventilatory Weaning considered Y / N / LEx			Has PVC been in situ > 72 hours Y / N		
Weaning plan considered Y / N / NA			Is pt on AB's Y / N (if N go to other activities)		
Chlorhexidine prescribed Y / N			Are antimicrobials still required Y / N		
Subglottic aspiration tube Y / N / Lx			Antimicrobials prescribed as per guidelines Y / N		
HMEF appropriate Y / N			Do antimicrobials require de-escalation Y / N		
Is wet circuit required?			Other activities		
Blood sugar - Is insulin required Y / N / LEx			DVT prophylaxis prescribed Y / N		
Is Insulin prescribed Y / N			Peptic ulcer prophylaxis prescribed Y / N / LEx		
Does patient have a central line Y / N (if N go to sepsis)			Patient up to sit Y / N / Lx		
New CVC line today Y / N			Daily goals / Plan written in medical notes		
Documentation completed Y / N			Kardex reviewed and re written as required Y / N		
Is CVC still required Y / N - If N remove {R} & send Tip for CSS			Blood results reviewed and actioned Y / N		
Is dressing intact Y / N			Assessed as per mobility chart Y / N		
Sepsis Screen - Is patient pyrexia Y / N			Is patient ready for discharge Y / N		
Has sepsis screen been completed Y / N			Receiving informed of discharge Y / N / NA		
Are there outstanding microbiology results Y / N			Discharge planning complete Y / N		
MRSA eradication therapy required Y / N			Discharge documentation completed Y / N		

Y = Yes

N = No

LEx = Local Exclusion

NA = Not Applicable

		01.00	02.00	03.00	04.00	05.00	06.00	07.00	08.00	09.00	10.00
R E S P I R A T I O N	Vent. Mode										
	FIO ₂										
	Rate/Set/Spont.										
	Press. Support/Cont										
	Peep/CPAP										
	T. Vol. Exp./I.PAP										
	M. Vol Exp./E.PAP										
	Peak Airway PR.										
	I:E / Humid Temp.										
	Air Entry L R										
	Hrly E.T./O.Ph/S.G. Aspirate										
	O ₂ Sats										
End Tidal CO ₂											
A B G S	H+ IONS										
	PCO ₂										
	PO ₂										
	HCO ₃ S										
	BE										
	Glucose/BM										
Sepsis screen											
Pupil Scale	1	•	40°								
	2	•	39°								
	3	•	38°								
	4	•	37°								
	5	•	36°								
	6	•	35°								
	7	•	34°								
	8	•	33°								
	K+	40°									
	Lactate	180									
	NIBP	160									
	ABP	140									
	HR	120									
	Red	100									
	Temp	80									
	Green	60									
	M.A.P.	40									
	Black	32°									
	Pupils: +/- Rhythm										
I N F U S I O N S	CVP										
	Rass/Pain										
	2 hrly Oral Hygiene										
	Drug PROSOL										
	Concentration/Pump No.										
	ALFENTANIL										
	PRIVILEX										
	Na HCO ₃										
	Position R/L/B head of bed >30°										
	Initials										
I N	Colloid										
	Drugs										
	Ng / Oral										
	Hourly Total										
O U T	Running Total										
	Urine										
	Gastric										
	Bowels / Stoma										
	Drain										
	CVWH										
	Hourly Total										
Running Total											
Balance											

COPY

NHS Forth Valley

Patient Nursing Transfer from Critical Care

Nursing Summary



Patient Details	GP Details
Patient CHI No: 3011795258	Practice Code: 25031
Patient Name: Mr Garry Scrimshaw	GP Name: Dr David S Borland
Date of Birth: 30/11/1979	GP Address: Health Centre Practice 3, Hallpark Road, Sauchie, FK10 3JQ
Address: 7 Moss Road,, Tillicoultry,, Clackmannanshire, FK13 6NS	

Consultant: Paterson, Dr Stuart
Date admitted to ICU / HDU: 20/08/2010
Date discharged from ICU / HDU: 21/08/2010

Details of Stay in ICU / HDU: Intubated for airway management. Ventilated overnight. Given IV Parvolex as per regime.

Patient Details at Time of Discharge:

Respiratory: Extubated at 09:30. Now self ventilating on room air.

Cardiovascular: Sinus rhythm. Normotensive.

Pain sedation: No sedation. Takes diclofenac and paracetamol for back pain

Neurological: GCS 15

Nutrition / Hydration: Free fluids and diet.

Elimination: Urinary catheter removed this a.m. still to pass urine.

Wound / Stoma / Drains:N/A

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General Body Condition:No problems.

Mobility:no Problems

Infection Status:Awaiting MRSA screen results. WCC normal

Today's Blood Results:

Na	138	Urea	3.0	HB	120	PT/Control	11/11.5
K+	3.7	Creatinine	89	WCC	8.2	APTT/Control	27/31
Chloride	111			Platelets	182	Fibrinogen	1.8

Patient and relatives understanding of health and ongoing care:Fully updated

Any Other Relevant Details:Awaiting psychiatric review.

Discharge Checklist:

Case notes:	
Date of blood transfusion added to case notes:	
Leaflet re blood transfusion given to patient:	
Nursing notes:	
X-Rays:	
Patient's own medication:	
Patient's belongings / clothing list completed:	
Check ward safe:	
Next of kin informed:	
Computer data completed:	

Patient ready for HDU / Ward transfer

Transferring Nurse: Margaret Thomson

Date: 21/8/10

Date: «EPISODE_DISCHARGE_DATE»

Name: Mr Garry Scrimshaw

Date of Birth: 30/11/1979

CHI No: 3011795258

FORTH VALLEY ACUTE HOSPITALS
Infusion Fluids / Blood Products Page



WARD		CONSULTANT		PATIENT DETAILS	
ALLERGIES - Please use RED INK				CHI: 3011795258 30/11/1979 M	
HEIGHT (m)	WEIGHT (kg)	DATE	SURFACE AREA (m ²)	HOSPITAL No: FK13 6NS	
				DATE OF BIRTH: AGE:	

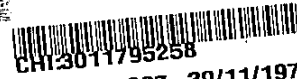


CHI: 3011795258
 SCRIMSHAW
 GARY
 7 MOSS ROAD
 TILLCOUNTRY
 FK13 6NS

COPY

- enter dosage times as 24hour clock
- please write in block capitals in black pen
- IV site MUST be checked prior to and after IV administration

A	APPROVED DRUG NAME	DOSE	ROUTE	START TIME	INFUSION STARTED BY:
	N. Saline	0.99%		1335	W Whyte
	TOTAL VOLUME			TIME STARTED	
	1000				
	DOCTORS SIGNATURE	DATE	RATE	PUMP NO.	BATCH NO.
	[Signature]	20/8/10	STAT		100111111 03/12
B	APPROVED DRUG NAME	DOSE	ROUTE	START TIME	INFUSION STARTED BY:
	N. Saline	0.99%		1405	W Whyte
	TOTAL VOLUME			TIME STARTED	
	500				
	DOCTORS SIGNATURE	DATE	RATE	PUMP NO.	BATCH NO.
	[Signature]	20/8/10			10E2115M 04/13
C	APPROVED DRUG NAME	DOSE	ROUTE	START TIME	INFUSION STARTED BY:
	TOTAL VOLUME			TIME STARTED	
	DOCTORS SIGNATURE	DATE	RATE	PUMP NO.	BATCH NO.
D	APPROVED DRUG NAME	DOSE	ROUTE	START TIME	INFUSION STARTED BY:
	TOTAL VOLUME			TIME STARTED	
	DOCTORS SIGNATURE	DATE	RATE	PUMP NO.	BATCH NO.
E	APPROVED DRUG NAME	DOSE	ROUTE	START TIME	INFUSION STARTED BY:
	TOTAL VOLUME			TIME STARTED	
	DOCTORS SIGNATURE	DATE	RATE	PUMP NO.	BATCH NO.
F	APPROVED DRUG NAME	DOSE	ROUTE	START TIME	INFUSION STARTED BY:
	TOTAL VOLUME			TIME STARTED	
	DOCTORS SIGNATURE	DATE	RATE	PUMP NO.	BATCH NO.
G	APPROVED DRUG NAME	DOSE	ROUTE	START TIME	INFUSION STARTED BY:
	TOTAL VOLUME			TIME STARTED	
	DOCTORS SIGNATURE	DATE	RATE	PUMP NO.	BATCH NO.
H	APPROVED DRUG NAME	DOSE	ROUTE	START TIME	INFUSION STARTED BY:
	TOTAL VOLUME			TIME STARTED	
	DOCTORS SIGNATURE	DATE	RATE	PUMP NO.	BATCH NO.



CHI:3011795258
CRN:S237397 30/11/1979
SCRIMSHAW GARRY
7 Moss Road,
TILLCOUNTRY,
Clackmannanshire
FK13 6NS

MRSA SCREENING RECORD

All ITU patients will be screened on admission and thereafter on a weekly basis. Additional screening should only be taken at a minimum interval of 48 hours after treatment has been discontinued. A further 2 full screens should be taken at intervals of no less than 48 hours between each screen. 3 full consecutive sets of screening swabs are required before the patient is considered free of MRSA carriage. [Infection Control Manual, SRI NHS Trust, September 2000]. Specimens are sent to microbiology accompanied by "white" form.

PLEASE TICK THE APPROPRIATE SPECIMEN BOX BELOW


SPECIMEN	28/3/10 Date	Result	Action	Date	Result	Action	Date	Result	Action
Nose - both nostrils	✓								
Throat	✓								
Axilla - 1 swab for both	✓								
Groins - 1 swab for both	✓								
CSU	CS								
Tracheal secretions	CS								
Invasive sites:									
1) Arterial Line	.....	.....	.....	.....	.....	.....	.....	.....	.....
2) Central line	.....	.....	.....	.....	.....	.....	.....	.....	.....
3) CVVH Line	.....	.....	.....	.....	.....	.....	.....	.....	.....
4) PA Catheter	.....	.....	.....	.....	.....	.....	.....	.....	.....
5) Venflon 1	.....	.....	.....	.....	.....	.....	.....	.....	.....
6) Venflon 2	.....	.....	.....	.....	.....	.....	.....	.....	.....
7) Venflon 3	.....	.....	.....	.....	.....	.....	.....	.....	.....
8).....	.....	.....	.....	.....	.....	.....	.....	.....	.....
Wound/Skin Lesions:									
1) Abdo wound	.....	.....	.....	.....	.....	.....	.....	.....	.....
2) Trache site	.....	.....	.....	.....	.....	.....	.....	.....	.....
3) Stoma	.....	.....	.....	.....	.....	.....	.....	.....	.....
4) Drain 1	.....	.....	.....	.....	.....	.....	.....	.....	.....
5) Drain 2	.....	.....	.....	.....	.....	.....	.....	.....	.....
6).....	.....	.....	.....	.....	.....	.....	.....	.....	.....
7).....	.....	.....	.....	.....	.....	.....	.....	.....	.....
8).....	.....	.....	.....	.....	.....	.....	.....	.....	.....

RE-SCREEN DATES IF MRSA POSITIVE

Date 1:

Date 2:

Date 3:


 CHI:3011795258
 CRN:S237397 30/11/1979
 SCRIMSHAW GARRY M
 7 Moss Road
 TILLCOUNTRY,
 Clackmannanshire
 FK13 6NS

Braden Risk Assessment Chart

Individuals with a total score of 16 or less are considered at risk:
 15 - 16 = low risk, 13 - 14 = moderate risk, 12 or less = high risk.

Undertake and document risk assessment within 6 hours of admission or on first home visit.
 Reassess if there is a change in individual's condition and repeat regularly according to local protocol

Date:

Sensory Perception - Ability to respond meaningfully to pressure related discomfort	1. Completely Limited Unresponsive (does not moan, flinch or grasp) to painful stimuli, due to diminished level of consciousness or sedation. OR limited ability to feel pain over most of body surface.	2. Very Limited Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness. OR has a sensory impairment that limits the ability to feel pain or discomfort over 1/2 of body.	3. Slightly Limited Responds to verbal commands, but cannot always communicate discomfort or need to be turned. OR has some sensory impairment that limits ability to feel pain or discomfort in 1 or 2 extremities.	4. No Impairment Responds to verbal commands. Has no sensory deficit that would limit ability to feel or voice pain or discomfort.	1
Moisture - Degree to which skin is exposed to moisture	1. Constantly Moist Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient/client is moved or turned.	2. Very Moist Skin is often, but not always, moist. Linen must be changed at least once a shift.	3. Occasionally Moist Skin is occasionally moist, requiring an extra linen change approximately once a day.	4. Rarely Moist. Skin is usually dry. Linen only requires changing at routine intervals.	3
Activity - Degree of physical activity	1. Bedfast Confined to bed.	2. Chairfast Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	3. Walks Occasionally Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. Walks Frequently Walks outside the room at least twice a day and inside the room every 2 hours during waking hours.	1
Mobility - Ability to change and control body position	1. Completely Immobile Does not make even slight changes in body or extremity position without assistance.	2. Very Limited Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	3. Slightly Limited Makes frequent though slight changes in body or extremity position independently.	4. No limitations Makes major and frequent changes in position without assistance.	7

Nutrition - Usual food intake pattern ①	1. Very Poor Never eats a complete meal. Rarely eats more than 1/3 of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement. OR is NPO and/or maintained on clear liquids or IV's for more than 5 days.	2. Probably Inadequate Rarely eats a complete meal and generally eats only about 1/2 of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement. OR receives less than optimum amount of liquid diet or tube feeding.	3. Adequate Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered. OR is on a tube feeding or TRN regimen which probably meets most of nutritional needs.	4. Excellent Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.
Friction and Shear ①	1. Problem Requires moderate to maximum assistance in moving.	2. Potential Problem Moves feebly or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair restraints, or other devices. Maintains relatively good position in chair or bed most of the time, but occasionally slides down.	3. No Apparent Problem Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times.	
Indicate appropriate number and add for total score				Total Score:

Date	Time	Score	Signature
20/8/10	18 ⁰⁰	8	M. Work

TOTAL BRADEN SCORE INDICATES THAT THE PATIENT IS:	EQUIPMENT WHICH SHOULD BE CONSIDERED FOR EACH "AT RISK" CATEGORY:
17+ : NOT AT RISK	Good quality mattress Depending on patient's individual requirements Overlay may be required for comfort, etc.
15 - 16: LOW RISK	PROPAD Mattress Overlay/Repose. Pressure reducing mattress, eg, SOFTFORM
12 - 14 : MODERATE RISK	If skin is intact, use pressure reducing mattress, eg, SOFTFORM/Repose OR If skin is broken up to a Stage 2 pressure ulcer, an active pressure relieving mattress overlay, eg, ALPHA X-CELL
9 - 11: HIGH RISK	Alternating Dynamic Pressure System, eg, AUTO X-CELL If skin is broken up to a Stage 3 pressure ulcer
6 - 8: SEVERE RISK	Alternating Dynamic Pressure System, eg, NIMBUS If skin is broken up to a Stage 4 pressure ulcer
RE-ASSESS THE PATIENT'S SCORE WHEN RE-EVALUATING OVERALL PROGRESS, IE, WEEKLY / MONTHLY, OR WHEN THERE IS A CHANGE / DETERIORATION IN THE PATIENT'S PHYSICAL CONDITION	An individual turning schedule should be implemented for each patient. If patient is out of bed, a pressure reducing / relieving seating system comparable to the equipment used on the bed should be considered, eg, Repose, Active Seat Cushion.

An initial pressure ulcer risk assessment should be performed and documented within six hours of admission.

Specialised Equipment

Type of equipment / aid -	Date Commenced	Date Discontinued

If applicable, date referred to Physiotherapist / Occupational Therapist / Dietician:

Has the patient fallen in the past year: Yes / No

Is the patient over 65 years of age Yes / No

If yes to any of the above:

- complete the falls risk assessment chart
- refer to physiotherapist as soon as possible
- supervise patients mobility
- provide a wheeled zimmer for patients use (refer to checklist on action plan)

Yes / No
Yes / No

Yes
Yes
Yes
Yes / No

Patient Name



CHI:3011795258
CRN:S237397 30/11/1979
SCRIMSHAW GARRY
7 Moss Road,
TILlicOUNTRY,
Clackmannanshire
FK13 6NS

M



Unit Number

Ward/Dept..... Weight.....

Date Transfer	OK	No. of Staff	No. of Staff	No. of Staff	No. of Staff	No. of Staff	No. of Staff	No. of Staff	No. of Staff	No. of Staff	No. of Staff	No. of Staff	Comments
Move up bed	RUO	2/3											
Turning in bed	RW	2/3											
Lying → sitting over edge of bed	BL	—											
Sit to Stand	BL	—											
Trolley ↔ bed	AS	4											
Toileting	CANISTER	—											
Bathing	BB	2											
Walking	BL	—											
Signature/Initial	M. [Signature]												

Codes

Assistance Required

- Independent Ind
- Supervised Sup
- Requires Help of 1/2/3/4...
- Hoist (specify) H
- Standaid S
- Bedrest BR
- Other - Specify

Method of Assistance

- Glide Sheet GS
- Multimover MM
- Folding Back Rest FBR
- Posterior Hold PH
- Combination Hold CH
- Patside/Rollerboard PS/RB
- Other - Specify


Mobility and mobility aids

- NM not to be mobilised
- NWB Non weight bearing
- PWB Partial Weight bearing
- FWB Full Weight bearing
- Walking Sticks WS
- Mobilator M
- Gutter Rollator GR
- Wheelchair W

Zimmer
Delta Rollator
Clutches
DR
C



Critical Care Department Care Plan

NAME: 
 CH/3011795258
 CRN: S237397 30/11/1979
 PREFERR: SCRIMSHAW GARRY M
 7 Moss Road
 TILLCOUNTRY,
 Clackmannanshire
 CHI NO: FK13 6NS

DAY NO: ①
 CRITICAL CARE CONSULTANT(S): Dr Maie
 REFERRING CONSULTANT:

DATE OF BIRTH: AGE:

PREVIOUS 24 HOUR SUMMARY (NIGHT SHIFT TO COMPLETE):

Admitted from A&E following on course of triazolic antidepressants & paracetamol
 & GCS - requiring intubation & ventilation.

DATE: 20/8/10

All nursing care documented in this care plan, is in accordance with Stirling Royal Infirmary NHS Trust procedures and guidelines and is used in conjunction with the Critical Care patient observation chart. Please delete as appropriate. Document care using a black pen (day duty). Use a green pen (night duty) when changes to patient assessment are found.

PHYSICAL ASSESSMENT OF CONDITION/NEEDS	AIMS AND PLANNED CARE
I. Respiratory Care	
Ventilation: on <i>Asimv</i> FiO_2 50% $PEEP$ = 15; RR 15	Maintain patent airway. Auscultate regularly. Pre-oxygenate: Yes/No
SpO_2 94% FiO_2 21%	Ensure optimum respiratory function/ventilation.
Chest Secretions: Nil	Sit Up 45° ✓
Regular Physio Yes/No	Aim for SpO_2 94%
Suctioning Required Yes/No	Monitor ABG's and act accordingly. ✓
ABG's: as dental.	
Tracheostomy: Yes (No)	Weaning: (Yes)/No Aim to reduce FiO_2 / $PEEP$
	Weaning plan: as date
Oxygen Therapy Yes/No	Prescribed Yes/No
Oxygen Percentage:	Delivery System:
	Reduce risk of lung infection 197 protocol

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Critical Care Department Care Plan

3. Cardiovascular Care		Aims Maintain Cardiac Stability
Cardiac Rhythm: <i>ST</i> / <i>P2</i> <i>Leads</i> Rate: <i>100-110</i>		Monitor vital signs and pressure traces frequency <input checked="" type="checkbox"/>
Blood Pressure: NIBP (APB) MAP:		Change electrodes daily
Inotropes Yes/No: <i>1 episode of hypertension ? cause</i> Type: Art line position: <i>RRA</i>		12 lead E.C.G. <input checked="" type="checkbox"/> / No done in A+E Aim for MAP: <i>70</i> Aim for CVP: <i>N/A</i>
CVP: <i>for 4h monitor</i> <i>+8 - +14</i>		Titrate Inotropes to ensure set parameters
Temperature: <i>35.5 - 37.7 °C</i>		Care of invasive monitoring lines : Flush Lumens x 1 per shift <input checked="" type="checkbox"/>
		: Flush Prescribed: Yes / No
		: Record CSM to digits per shift

PHYSICAL ASSESSMENT OF CONDITION/NEEDS	AIMS AND PLANNED CARE
3. Pain/Sedation	
Sedation: <i>RASS = -5</i>	Aim for sedation score: <i>RASS = 0</i>
Sedation Holiday <i>Yes/No N/A</i> <i>Propofol Allentrol epidural in progress</i>	
Pain: <i>No obvious signs of pain / discomfort</i>	Observe for non-verbal signs of pain frequency Assess effectiveness of analgesia and characteristics of pain. <input checked="" type="checkbox"/> Aim for pain score
4. Neurological Care	
Neurological State: <i>Best 4+/4+</i>	Observe for neurological deterioration and report any changes.
Pupils	Record GCS AVPU Score x 1 per shift 4
5. Nutrition/Hydration	
NBM/Feeding / Oral Fluids / Diet Type	Liase with the dietician and the anaesthetist re feeding regime
Feed Enteral / Parenteral	Encourage / Provide adequate nutrition
Feed Type	Change NG fixing tape daily.
Tube type: Ryles / Fine Bore	
Position:	
<i>? for N/G tube</i> <i>ON FACE</i>	
Gastric Aspirates: PH: <i>DEADENITOL</i>	Record blood glucose <i>2-3</i> hourly.
	Aim for Blood Glucose: 3.8 - 8.5
	Encourage oral fluids / diet supplements: Yes / No <input checked="" type="checkbox"/>
Blood Sugar: <i>as clinical</i>	Maintain an accurate fluid balance. <input checked="" type="checkbox"/>
Sliding scale insulin regime prescribed: <input checked="" type="checkbox"/> No <i>NO</i>	Weekly weight complete nutritional risk screening tool.

Critical Care Department Care Plan

PHYSICAL ASSESSMENT OF CONDITION/NEEDS	AIMS AND PLANNED CARE
6. Continuation Renal function: <i>Urinary catheter (Size 16 / 10 ml in balloon)</i> <i>meted using aseptic technique</i> <i>Good urine output</i>	Care of urinary catheter Hourly Volumes / Free Drainage Daily urea and electrolytes Daily Urinalysis
Renal replacement therapy: Yes <input checked="" type="radio"/> No <input type="radio"/>	Aim for a +ve / -ve balance of: Maintain an accurate fluid balance
IV Anticoagulant Vascath site:	Maintain safe / effective renal replacement therapy. Care of renal replacement lines / maintain patient safety. Maintain APPT ratio of:
Drains / Output	
Abdomen Distended <input checked="" type="radio"/> Soft <input type="radio"/> Bowels last open:	Prevent Constipation
Colostomy / Ileostomy / Mucoid Fistula	
Stoma Condition: Appliance Type:	? Refer to Stoma Care Team.
7. Personal	
General body condition: <i>Satisfactory</i>	Maintain appropriate hygiene standards and dignity.
Mouth condition: <i>Dry</i>	Bed bath / shave / hair wash / finger nails / toe nails / catheter care
Eye condition: <i>OK</i>	
Arterial Line site: <i>OK</i>	Ensure occlusive dressing is intact to all line sites.
Central Line: <i>OK</i>	
Venflon site/s: <i>Satisfactory => removed</i>	
Wound (s): <i>n/a</i>	Redress:
Drains:	Aim for healthy granulation of wounds Reduce Infection

Critical Care Department Care Plan

8. Mobility		Aim
Pressure areas: <i>upper chest</i>		Reassess all pressure areas <i>4</i> hourly.
Sunderland Score / Waterlow / Braden		Turning / repositioning required <i>4</i> hourly.
Mobility: <i>Bed Rest / Up to sit</i>		Therapeutic Mattress: Yes / <input checked="" type="radio"/> No Type:
Teds in situ: <i>4/2/2/2/1</i> Size: Length:		Manual handling technique:
LMWH: Yes / <input checked="" type="radio"/> No Prescribed: <i>✓</i>		Mobility Chart Falls Risk Assessment
		Reduce Risk Factors of DVT
9. Infection		
WCC elevated: Yes / <input checked="" type="radio"/> No		Damp dust bedspace each shift .
		Inform relatives about hand washing
MRSA + ve: Yes / <input checked="" type="radio"/> No <i>screened</i> Site/s:		
Microbiology Sites:		
Patient isolation: yes / <input checked="" type="radio"/> no		
10. Psychological / Cultural		Aim
Patient's psychological condition: <i>Subtotal of ventilated</i>		Communication tools: lip reading / alphabet / speaking tube
Family: <i>a wife visited & updated</i>		Orientate patient to time, place and person.
Sleep/rest: <i>day / night routine</i>		Explain all plans procedures to patients and family.
Spirituality: <i>Not discussed</i>		Give reassurance / support to patient.
		Encourage involvement in decision making.
		Maintain the environment conducive to sleep / rest periods.
		Reduce unnecessary noise / alarms.
		Accommodate religious / cultural / spiritual needs.
		Maximise stimulation when appropriate - visitors
		TV / radio / newspapers / photographs

Day shift assessed by: *M. Cold* (Signature) *M. CORKISH* (PRINT NAME) *SCN* (Job title) *17:30* (Time)

Night shift assessed by: *J. Horner* (Signature) *G. DARNELL* (PRINT NAME) *WVY* (Job title) *6:30* (Time)

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Nursing Evaluation Cont.

- Night Report: ① PO_2 weaned overnight to 21%, RR 6 13 bpm due to ↓ CO_2 . Will start changes in ventilation.
- ② RR 20 bpm, normoventilator, Temp 37.5 - 38.0. Adequate oximetry in rt.
- ③ Propofol 7 10 ml/hr ⇒ waking up - uncooperative, at risk of self-extubation.
- ④ Waking up, RR 20 (needs all limbs), unaware of surroundings.
- ⑤ NGT on free drainage overnight - 200 ml out. Bowel stable, IV fluids + Tabrex overnight.
- ⑥ Adequate I/O.
- ⑦ Regular oral care q 2h - nurse doing. Both nipples unhealed. Engo & Procto in rt (just revised). NGT replacement univols, all replacement 100 ml in rt overnight.
- if intubated @ 2200 - hydrated by feeding through, appeared he wishes to be the only part of contact. Expressed worries re-yesterday's events mental health prior to OD - puts it will be addressed. All care given.

COPY

Day Report:

Condition improved over morning, extubated and now S/V on R.A. RR 14-20 SpO₂ 95%.

C.V.S stable. Appexial. Central line & a-line can be removed when venflon inserted.

No cp pain.

Remains drowsy and "weepy" at times.

Oral fluids and diet as desired.

H.N.P.V. once, catheter removed.

Wife has visited.

C - transferred to Ward when bed available.

To have ~~psych~~ psych review before discharge.

at C. Thomson S/N.

(THOMSON)

8:45 pm. Central line removed, tip sent for CRS.

Pink ventlon inserted.

Tried to get out of bed & stumbled but caught by wife before he hurt himself.

Becoming more cheerful and wanting to go home.

Events

01.00	PAC => (2)	COPY	Initials
02.00	KCC replacement - 40 mols		
03.00			
04.00			
05.00	Propofol 7 Wnd / hr - waking up, moving - unresponsive		
06.00	PAC => (2), KCC replacement 2 mols		2
07.00			
08.00	Bad chestes.		MS
09.00	Sedation break		
10.00	Extubated at 09.55. RR 19, SpO2 88% -> 96% Flow 5 L/min		AD
11.00	Urinary catheter out. Taking oral fluids		A
12.00	Refused lunch.		A
13.00			
14.00			
15.00			
16.00			
17.00			
18.00			
19.00			
20.00			
21.00			
22.00			
23.00			
00.00			

	AM	PM		AM	PM
Admitting team aware Y / N			Does patient have a PVC Y / N (if N go to AB's)		
APACHE II score complete Y / N	NA	NA	New PVC today		
Wardwatcher up to date Y / N			Documentation/sticker completed Y / N		
Is patient ventilated Y / N (if N go to blood sugars)			Is PVC still required Y / N (if N then remove R)		
HOB > 30° Y / N			Evidence of inflammation / erythema Y / N		
Sedation Holiday appropriate Y / N / L.Ex / NA			Dressing intact Y / N		
Ventilatory Weaning considered Y / N / L.Ex			Has PVC been in situ > 72 hours Y / N		
Weaning plan considered Y / N / NA			Is pt on AB's Y / N (if N go to other activities)		
Chlorhexidine prescribed Y / N			Are antimicrobials still required Y / N		
Subglottic aspiration tube Y / N / Lx			Antimicrobials prescribed as per guidelines Y / N		
HMEF appropriate Y / N			Do antimicrobials require de-escalation Y / N		
Is wet circuit required?			Other activities		
Blood sugar - Is insulin required Y / N / L.Ex			DVT prophylaxis prescribed Y / N		
Is Insulin prescribed Y / N			Peptic ulcer prophylaxis prescribed Y / N / L.Ex		
Does patient have a central line Y / N (if N go to sepsis)			Patient up to sit Y / N / Lx		
New CVC line today Y / N			Daily goals / Plan written in medical notes		
Documentation completed Y / N			Kardex reviewed and re written as required Y / N		
Is CVC still required Y / N - If N remove (R) & send Tip for C&S			Blood results reviewed and actioned Y / N		
Is dressing intact Y / N			Assessed as per mobility chart Y / N		
Sepsis Screen - Is patient pyrexia Y / N			Is patient ready for discharge Y / N		
Has sepsis screen been completed Y / N			Receiving informed of discharge Y / N / NA		
Are there outstanding microbiology results Y / N			Discharge planning complete Y / N		
MRSA eradication therapy required Y / N			Discharge documentation completed Y / N		

Y = Yes N = No LEx = Local Exclusion NA = Not Applicable

Critical Care Department Care Plan

NAME:



CHI 3011795258
CRN: S237397 30/11/1979

DAY NO: 2

CRITICAL CARE CONSULTANT(S): Dr. [unclear]

PREFERRED NAME:

SCRIMSHAW GARRY M

REFERRING CONSULTANT: Dr.

CHI NO:

7 Moss Road,
TILLCOUNTRY,
Clackmannanshire
FK13 6NS

AGE: 30

PREVIOUS 24 HOUR SUMMARY (NIGHT SHIFT TO COMPLETE):

Ventilated + sedated overnight
One episode of haemodynamic instability - resolved - will further episodes
None - well up, re-absorb.

DATE: 21/8/2010

All nursing care documented in this care plan, is in accordance with Stirling Royal Infirmary NHS Trust procedures and guidelines and is used in conjunction with the Critical Care patient observation chart. Please delete as appropriate. Document care using a black pen (day duty). Use a green pen (night duty) when changes to patient assessment are found.

PHYSICAL ASSESSMENT OF CONDITION/NEEDS	AIMS AND PLANNED CARE
I. Respiratory Care	
Ventilation: <i>Self-ventilating on RA</i> <i>RR 16 - 19 SaO₂ > 95%</i>	Maintain patent/airway. Auscultate regularly. Pre-oxygenate: Yes (No) ✓ Ensure optimum respiratory function / ventilation. ✓ Sit Up 45° ✓
Chest Secretions: <i>nil</i>	Aim for SpO ₂ > 93%
Regular Physio (Yes) / No	Monitor ABG's and act accordingly. ✓
Suctioning Required Yes (No)	ABG's:
Tracheostomy: Yes / No	Weaning: Yes / No
	Weaning plan: <i>N/A</i>
Oxygen Therapy Yes / No	
Prescribed Yes / No	
Oxygen Percentage:	Delivery System:
	Reduce risk of lung infection ✓

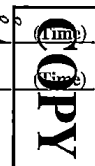
COPY

Critical Care Department Care Plan

8. Mobility	Aim
Pressure areas: <u>Intact</u>	Reassess all pressure areas 3-4 hourly.
	Turning / repositioning required 3-4 hourly.
Sunderland Score / Waterlow	Therapeutic Mattress: Yes (No) Type:
Mobility Bed Rest / Up to sit	Manual handling technique: <u>GL + 2 nurses</u>
Teds in situ: Size: Length:	Mobility Chart Falls Risk Assessment
LMWH (Yes/No) Prescribed:	Reduce Risk Factors of DVT
9. Infection	
WCC elevated: Yes (No) <u>8.2</u>	Damp dust bedspace each shift.
	Inform relatives about hand washing
MRSA + ve: Yes / No <u>awaked</u> Site/s:	
Microbiology Sites:	
Patient isolation: yes (no)	
10. Psychological / Cultural	Aim
Patient's psychological condition:	Communication tools: lip reading / alphabet / speaking tube <u>N/A</u>
Family: <u>Ex-wife updated by phone</u>	Orientate patient to time, place and person. ✓
Sleep/rest:	Explain all plans procedures to patients and family. ✓
Spirituality:	Give reassurance / support to patient. ✓
	Encourage involvement in decision making. ✓
	Maintain the environment conducive to sleep / rest periods. ✓
	Reduce unnecessary noise / alarms. ✓
	Accommodate religious / cultural / spiritual needs. ✓
	Maximise stimulation when appropriate - visitors
	TV / radio / newspapers / photographs

Day shift assessed by: Meghan Thomson (Signature) M C THOMSON (PRINT NAME) S/N (Job title) W

Night shift assessed by: _____ (Signature) _____ (PRINT NAME) _____ (Job title)



2. Cardiovascular Care		Aims Maintain Cardiac Stability
Cardiac Rhythm: <i>Sinus Rhythm</i> Rate: <i>88-96</i>		Monitor vital signs and pressure traces frequency ✓
Blood Pressure: NIBP/APB <i>160/90</i> MAP: <i>>90</i>		Change electrodes daily ✓
Inotropes Yes <i>(No)</i> Type: _____ Art line position: <i>(R) Radial</i>		12 lead E.C.G. Yes <i>(No)</i>
	<i>Removed ✓</i>	Aim for MAP: <i>>75</i> Aim for CVP: <i>8-12</i>
CVP: <i>+10</i>		Titrate Inotropes to ensure set parameters
Temperature: <i>36.2</i>		Care of invasive monitoring lines : Flush Lumens x 1 per shift ✓
		: Flush Prescribed: Yes <i>(No)</i>
		: Record CSM to digits per shift ✓

PHYSICAL ASSESSMENT OF CONDITION/NEEDS **AIMS AND PLANNED CARE**

3. Pain/Sedation	
Sedation:	Aim for sedation score: <i>0</i>
Sedation Holiday Yes <i>(No)</i>	<i>Drowsy</i>

Pain: <i>No do pain</i>	Observe for non-verbal signs of pain frequency ✓
	Assess effectiveness of analgesia and characteristics of pain. ✓
	Aim for pain score <i>0</i>

4. Neurological Care	
Neurological State: <i>Drowsy & weepy</i>	Observe for neurological deterioration and report any changes.
Pupils <i>6.5 15</i>	Record GCS AVPU Score x 1 per shift ✓

5. Nutrition/Hydration	
NBM/Feeding <i>(Oral Fluids)</i> Diet Type <i>Normal</i> ✓	Liase with the dietician and the anaesthetist re feeding regime
Feed Enteral / Parenteral Tube type: <i>Ryles / Fine Bore</i>	<i>(Encourage)</i> Provide adequate nutrition ✓
Feed Type Position: <i>Removed 11.00</i>	Change NG fixing tape daily. <i>NA</i>

Gastric Aspirates: _____ PH: _____	Record blood glucose <i>DAILY</i> hourly.
	Aim for Blood Glucose: <i>3.8 - 8.5</i> ✓
Blood Sugar: <i>4.6 mmols</i>	Encourage oral fluids / diet supplements: Yes <i>(No)</i>
Sliding scale insulin regime prescribed: Yes <i>(No)</i>	Maintain an accurate fluid balance. ✓
	Weekly weight complete nutritional risk screening tool. ✓

COPY

Critical Care Department Care Plan

PHYSICAL ASSESSMENT OF CONDITION/NEEDS	AIMS AND PLANNED CARE
6. Elimination	
Renal function: <i>Urinary catheter in situ - removed at 11:00. Urinary output adequate. U & E's satisfactory.</i>	Care of urinary catheter ✓ <i>Hourly Volumes/ Free Drainage</i> Daily urea and electrolytes ✓ <i>Daily Urinalysis</i> ✓ Aim for a +ve / -ve balance of: <i>neutral</i> Maintain an accurate fluid balance ✓
Renal replacement therapy: Yes (No) <input checked="" type="checkbox"/> IV Anticoagulant Vascath site:	Maintain safe / effective renal replacement therapy. Care of renal replacement lines / maintain patient safety. } <i>N/A</i> Maintain APPT ratio of:
Drains / Output Abdomen Distended (Soft) <input checked="" type="checkbox"/> Bowels last open: <i>pre admission</i> Colostomy / Ileostomy / Mucoid Fistula Stoma Condition: Appliance Type:	Prevent Constipation ? Refer to Stoma Care Team.
7. Personal	
General body condition: <i>Skin clean & intact</i>	Maintain appropriate hygiene standards and dignity.
Mouth condition:	Bed bath / shave / hair wash / finger nails / toe nails / catheter care ✓
Eye condition: <i>eyelids "puffy"</i>	<i>refused shave today</i> ✓
Arterial Line site: (R) radial - <i>satisfactory</i>	Ensure occlusive dressing is intact to all line sites. ✓
Central Line: (R) I.V. - <i>satisfactory</i>	
Venflon site/s: <i>N/A</i>	
Wound (s): <i>N/A</i>	Redress:
Drains:	Aim for healthy granulation of wounds Reduce Infection

COPY

Other Charts in use (Please tick) Insulin Anticoagulant Pain Additional Kardex Other

FORTH VALLEY HEALTH SERVICES

COPY

MEDICATION PRESCRIPTION & ADMINISTRATION RECORD SHEET

WARD: _____ CONSULTANT: _____

ALLERGIES: _____ NKDA (Please circle if appropriate)

(one of these boxes must be filled in)

Initial here when informed verbal consent to use/destroy P.O.D.'s received from the patient.

PATIENT DET/ (and Address)

CHI: 3011795258 30/11/1979 M

SCRIMSHAW GARY
7 MOSS ROAD
TILLCOUNTRY
FK13 6NS

HOSPITAL: _____

DATE OF BIRTH: _____

Drugs administered prior to hospital arrival

Date	Approved Drug Name	Dose	Route	Given by (e.g. SAS, GP)	Time given
	Naloxone	400µg	IV	SAS	1255h

ONCE ONLY MEDICATION

PHARMACY	DATE	APPROVED DRUG NAME	DOSE	ROUTE	TIME/ INSTRUCTIONS	DR SIGNATURE	GIVEN BY	TIME GIVEN
		Sodium bicarbonate 8.4%	50ml					1338

INSTRUCTIONS FOR USING THIS SHEET

- Doctors and Nurses must ONLY write in black ink (except for allergies)
 - Pharmacists must ONLY use green ink
 - Use the approved drug (RINN) name and write in BLOCK CAPITALS
 - Enter the specified times and write additional information in the instruction box.
 - ONLY use the listed abbreviated routes of administration. Where the abbreviation is not listed, write the route in full.
 - Dose must be stated in either metric or SI units. Quantities less than 1mg must be written in full eg. micrograms.
 - To cancel a drug draw a diagonal line through the entire entry, initial and date.
 - TWO nurses must initial each drug administration for ALL Parenteral and Paediatric Medicine.
 - When a drug is not given - enter the not given code (see list)
 - ALL of the above MUST be adhered to
- | ROUTES | NOT GIVEN CODES |
|--------------------|--------------------------------------|
| IV - intravenous | 1. Patient not on ward |
| IM - intramuscular | 2. Patient unable to take |
| SC - subcutaneous | 3. Patient vomited |
| PO - oral | 4. Drug not available |
| INH - inhaled | 5. Drug not required |
| NEB - nebulised | 6. Given > 30 mins late (state time) |
| SL - sublingual | 7. Patient allergy |
| PR - by rectum | 8. Patient refused |
| PV - by vagina | 9. Withheld - medical indication |
| TOP - topical | 10. Given by Patient/relative/carer |

KARDEX C

PHARMACY USE ONLY

NAME: _____ Unit No: _____ 2

General Medication Oral and other routes (regular)

(General Medication starts at page 2 and works forward. Parenteral Medication starts at page 4 and works forward)

- enter dosage times as 24hour clock
- please write in block capitals
- please write in black pen

- Maximum of 3 continuation sheets
- please ensure patient details are on each sheet

COPY

ALLERGIES - Please use RED INK N K D A (Please circle if appropriate) DATE 22/10/10

(one of these boxes must be filled in)

Drug OXYGEN

Circle target oxygen saturation
 88-92% 94-98% Other _____

Starting device/flow rate _____

PRN/continuous (refer to O₂ guideline)

Tick here if saturation not indicated*

Date and signature _____

Print name _____

APPROVED DRUG NAME NILCORNE PARZIT	DOSE 15mg	ROUTE ORALS DORAL
--	---------------------	---------------------------------

INSTRUCTIONS REMOVE AT NIGHT	Clin Pharm.	Reg/New
Date stopped		

SIGNATURE 	DATE 21/10/10	Reason for stopping
---------------	-------------------------	---------------------

APPROVED DRUG NAME	DOSE	ROUTE
--------------------	------	-------

INSTRUCTIONS	Clin Pharm.	Reg/New
Date stopped		

SIGNATURE	DATE	Reason for stopping
-----------	------	---------------------

APPROVED DRUG NAME	DOSE	ROUTE
--------------------	------	-------

INSTRUCTIONS	Clin Pharm.	Reg/New
Date stopped		

SIGNATURE	DATE	Reason for stopping
-----------	------	---------------------

APPROVED DRUG NAME	DOSE	ROUTE
--------------------	------	-------

INSTRUCTIONS	Clin Pharm.	Reg/New
Date stopped		

SIGNATURE	DATE	Reason for stopping
-----------	------	---------------------

APPROVED DRUG NAME	DOSE	ROUTE
--------------------	------	-------

INSTRUCTIONS	Clin Pharm.	Reg/New
Date stopped		

SIGNATURE	DATE	Reason for stopping
-----------	------	---------------------

SUPPLY

SUPPLY

SUPPLY

SUPPLY

SUPPLY

SUPPLY

SUPPLY

PATIENT PROFILE

Addressograph: Name: <u>GARY Scrimshaw</u> Address: <u>43 EAST Castle STREET</u> <u>ALLOA FK10 1BB</u> DoB: <u>30.11.79</u> Unit No: <u>237397</u> Prefers to be addressed as: _____ Age: <u>26</u>		Consultant: Ward: <u>29B</u> Pre-op Date: _____ Date of Admission: _____ Time of Admission: _____ Readmission Date: _____	
Provisional Diagnosis: <u>(L) eye injury</u> <u>P corneal abrasion</u>		Final Diagnosis / Treatment:	
Next of Kin: Name: <u>MRS Scrimshaw</u> Address: <u>43 EAST Castle STREET</u> <u>ALLOA.</u> Relationship: <u>wife.</u> Tel. Day: _____ Mobile: <u>07706396071.</u> Tel. Night: _____		Name: _____ Address: _____ Relationship: _____ Tel. Day: _____ Mobile: _____ Tel. Night: _____	
G.P. <u>DR Borkard.</u> Practice: <u>Alloa medical centre</u> Transport req. for discharge: YES: _____ Ref.No: _____ NO: will collect.		Own Medication: Y: <input type="radio"/> N: <input checked="" type="radio"/> In Cupboard: Y: <input type="radio"/> N: <input checked="" type="radio"/> Returned to relatives: Y: <input type="radio"/> N: <input checked="" type="radio"/>	
Urinalysis: Date: _____ Uroblinogen: _____ Bilirubin: _____ Protein: _____ Sp.Grav: _____ Blood: _____ Glucose: _____ PH: _____ Ketone: _____		Bladder: Continent/Incontinent: <u>Continent</u> LMP: _____ Pregnancy Test: REQ: YES: _____ N/A: _____ Date: _____	
Bowel: <u>Normal.</u> BLO: _____ Stoma Nurse Referral: N/A: YES: _____ Date: _____		Diet: <u>Normal</u> Weight: _____ Kg Appetite: _____ Dietetic Referral: YES: _____ Date: N/A: _____	
Teeth: _____ Eyesight: } <u>no problems.</u> Hearing: }		Religion: <u>NIK.</u> Marital Status: <u>married</u> Occupation: <u>Chef</u>	
Understanding of Illness / Surgery <u>fully aware</u> Patient spoken to by: _____ Relatives spoken to by: _____			
Admitted by: <u>S.J. WOTHERSPOON</u> Named Nurse on Admission: _____		Date: <u>26.10.06.</u>	

COPY

Home Circumstances

Who lives with patient: <u>WIFE</u> Shops/Cooks/Laundry: <u>SELF</u> Type of House: Facilities on one level: YES: NO: Shower or Bath: Self or Assisted:	MECS: Home Help: Frequency: Meals on Wheels: YES: NO: Frequency: District Nurse: YES: NO: Frequency and reason: Social Work involvement: YES: NO: Contact name: Referral made: YES: Date:
Mobility (prior to admission) <u>independent</u> (see mobility chart) Physio referral: YES Date: N/A: OT referral: YES: Date: N/A: Chiropody referral :YES: Date: N/A:	<div style="border: 2px solid black; padding: 5px; font-size: 2em; font-weight: bold; margin: 0 auto;">COPY</div>
Valuables:	
Sent Home: YES: Date: Details: Retained: YES: Date: Advised re Policy: YES: Date: Clothing List: YES: Date:	Ward Safe: YES: Date: Details: Returned to patient: Date: Admin. Office: YES: Date: Details: Returned to patient: Date:
If patient transferred to HDU, clothing retained in .....Valuables retained in.....	

Discharge Checklist	Date & Sign
Next of Kin aware of discharge date / Nursing home informed.	✓ <u>CD</u> 27/10/06
Discharge letter headed: <input type="checkbox"/> Completed and in pharmacy: <input type="checkbox"/> Meds. On ward:	
Social Services aware of discharge date.	N/A
Specialist Nurses aware of discharge date.	N/A
Dietician aware of discharge date.	N/A
Physio. / OT aware of discharge date.	N/A
Written Information / Advice leaflet if applicable / Discharge summary.	N/A
Verbal advice given.	✓ <u>CD</u> 27/10/06
Valuables returned to patient.	N/A
Venflon removed.	N/A
Own medication returned to patient. (checked by two nurses)	N/A
Discharge Prescription and GP letter given to patient. (checked by two nurses)	
Outpatient appointment made and given to patient. <u>Eye clinic 30/10/06 - has apt card</u>	
District Nurse / Health Visitor contacted. By ward staff: <input type="checkbox"/> Liaison Staff: <input type="checkbox"/>	N/A
Comments:	
Signature of Nurse: <u>CD Denolt</u> 27/10/06	

NURSING NOTES

Write - imprint or Attach Label

Surname Scrimshaw Hospital No.

Forenames GARY Sex M

D. of B. 30.11.79

Address

COPY
Ward / Dept. 29B

Consultant

Date

26.10.06 Admitted to ward 29B via eye clinic. Referred
15⁰⁰ hrs to eye clinic by GP with (L) eye injury for
12 hourly eye drops. Checked in by Jno. All
observations stable on admission. Settled since
admission. For review in the am. SJ Wetherston

27/10/06 NO Eyedrops given $\frac{1}{2}$ hrly throughout night
so patient not had much sleep. Eye
red slightly swollen and weepy. Has been
very uncomfortable overnight. D. hydrocodone
30mg given at 02.10. H/Simmy

as. Attended eye clinic.
Len changed to a smaller size.
Eyedrops (ofloxacin) to continue 6x daily.
May be discharged now.
Patient has eye clinic appt for Monday 30/10/06
Crisdenold Fr.

COPY

Date

NURSING NOTES
 (Also to be used for Short Term
 Patients instead of Nursing Profile)

Surname ...
 Forenames ... CHI: 3011795258
 CRN: S2 237397 30/11/1979
 Address ... SCRIMSHAW GARRY M
 43 EASTCASTLE STREET
 ALLOA
 FK10 1BB

COPY
 Ward 7 Dept

19

Date EXOCIN (L) EYE 1/2 HRLY

DATE	TIME	SIGNATURE
26.10.06	9.30	H Berry
	10.00	H Berry
	10.30	H Berry
	11.00	H Berry
	11.30	H Berry
	12.00	H Berry
27/10/06	00.30	H Berry
"	01.00	H Berry
"	01.30	H Berry
"	02.00	H Berry
"	02.30	H Berry
"	03.00	H Berry
"	03.30	H Berry
"	04.00	Jm
"	04.30	Jm
"	05.00	H Berry
"	05.30	H Berry
"	06.00	H Berry
"	06.30	H Berry
"	07.00	
"	07.30	Emdenott
"	08.00	Emdenott
	08.30	Emdenott
	09.00	Emdenott
	09.30	
	10.00	

General Medication Page

(General Medication starts at front and works forward. Intravenous Medication starts at back and works forward)

- enter dosage times as 24hour clock
- please write in block capitals
- please write in black pen

- Maximum of 3 continuation sheets (only for patients with Consultants approval).
- please ensure patient details on each sheet

COPY

		DATE →																		
		TIME ↓																		
APPROVED DRUG NAME		DOSE	ROUTE																	
G. Exocin			1																	
INSTRUCTIONS		PHARMACY																		
Dose: 1/2 hourly		Clin																		
SIGNATURE		DATE	POD	Y	N															
[Signature]		26-10-06	D/C	Y	N															
		DISP ₁																		
		DISP ₂																		
APPROVED DRUG NAME		DOSE	ROUTE																	
ARACETAMOL		1g	PO				0800		1600											
INSTRUCTIONS		PHARMACY																		
[Signature]		DATE	Clin																	
[Signature]		27/10/06	POD	Y	N															
		D/C	Y	N																
		DISP ₁																		
		DISP ₂																		
APPROVED DRUG NAME		DOSE	ROUTE																	
INSTRUCTIONS		PHARMACY																		
		Clin																		
SIGNATURE		DATE	POD	Y	N															
			D/C	Y	N															
		DISP ₁																		
		DISP ₂																		
APPROVED DRUG NAME		DOSE	ROUTE																	
INSTRUCTIONS		PHARMACY																		
		Clin																		
SIGNATURE		DATE	POD	Y	N															
			D/C	Y	N															
		DISP ₁																		
		DISP ₂																		
APPROVED DRUG NAME		DOSE	ROUTE																	
INSTRUCTIONS		PHARMACY																		
		Clin																		
SIGNATURE		DATE	POD	Y	N															
			D/C	Y	N															
		DISP ₁																		
		DISP ₂																		
APPROVED DRUG NAME		DOSE	ROUTE																	
INSTRUCTIONS		PHARMACY																		
		Clin																		
SIGNATURE		DATE	POD	Y	N															
			D/C	Y	N															
		DISP ₁																		
		DISP ₂																		
APPROVED DRUG NAME		DOSE	ROUTE																	
INSTRUCTIONS		PHARMACY																		
		Clin																		
SIGNATURE		DATE	POD	Y	N															
			D/C	Y	N															
		DISP ₁																		
		DISP ₂																		
APPROVED DRUG NAME		DOSE	ROUTE																	
INSTRUCTIONS		PHARMACY																		
		Clin																		
SIGNATURE		DATE	POD	Y	N															
			D/C	Y	N															
		DISP ₁																		
		DISP ₂																		

Pharmacy Codes: Clin = Professional Clinical Check
 POD = patient own drugs available and suitable for use
 D/C = drug to be continued on discharge
 Disp = Supply dispensed labelled and checked

Initial Date Y N Quantity Y N No. of Days Initial Date Quantity

As Required Medication Page

(Prescribers MUST enter indication, dosage interval and maximum daily dose)

COPY

- enter dosage times as 24hour clock
- please write in block capitals in black pen

- Maximum of 3 continuation sheets (or 5 for long stay patients with Consultants approval).
- please ensure patient details on each sheet

			DATE →						
APPROVED DRUG NAME			DOSE	ROUTE	TIME				
Sodium Chloride 0.9%				IV					
INSTRUCTIONS			PHARMACY		GIVEN BY				
for flush			Clin		TIME				
			POD	Y N	GIVEN BY				
			D/C	Y N	TIME				
SIGNATURE	DATE	DISP ₁			GIVEN BY				
		DISP ₂							
APPROVED DRUG NAME			DOSE	ROUTE	TIME	02-10			
DIHYDROCODEINE			30mg	PO					
INSTRUCTIONS			PHARMACY		GIVEN BY				
every 4 to 6 hours			Clin		TIME				
			POD	Y N	GIVEN BY				
			D/C	Y N	TIME				
SIGNATURE	DATE	DISP ₁			GIVEN BY				
		DISP ₂							
APPROVED DRUG NAME			DOSE	ROUTE	TIME				
INSTRUCTIONS			PHARMACY		GIVEN BY				
			Clin		TIME				
			POD	Y N	GIVEN BY				
			D/C	Y N	TIME				
SIGNATURE	DATE	DISP ₁			GIVEN BY				
		DISP ₂							
APPROVED DRUG NAME			DOSE	ROUTE	TIME				
INSTRUCTIONS			PHARMACY		GIVEN BY				
			Clin		TIME				
			POD	Y N	GIVEN BY				
			D/C	Y N	TIME				
SIGNATURE	DATE	DISP ₁			GIVEN BY				
		DISP ₂							
APPROVED DRUG NAME			DOSE	ROUTE	TIME				
INSTRUCTIONS			PHARMACY		GIVEN BY				
			Clin		TIME				
			POD	Y N	GIVEN BY				
			D/C	Y N	TIME				
SIGNATURE	DATE	DISP ₁			GIVEN BY				
		DISP ₂							

