

Surname Crafton
First Names Leon
Maiden Surname
Address

Unit No.

Date seen or Admitted

Seen at

Seen by

Consultant in Charge

Family Dr.

Referred by

D. of B.

Sex M. F.

M.S.W.D.

Religion

Occupation

R/L

At ease, pleasant. Dressed in pyjamas.
Evidence hyperaesthesia / responding to hallucinations
and EC, "abnormal movements".

S: Q rate & intonation

M: O enthusiastic, reactive

S: "fed up" of these voices?
"depressed" no ongoing suicidal intent

poor sleep
appetite $\rightarrow$

P Describes hearing "noise" at night
and "noises" like the "roar of a jail"

Voices -
people talking
- no clear
description
distance

C Orientated TPP.

D Wishes a $\uparrow$ hospital depot
has worked "to a degree" but doesn't feel
he is on enough medication

Took the overdose of meprobamate - "he wanted a few d sleep
but also "wanted to die" - despite having mother afterwards!
Has been feeling "paranoid" since taking cannabis from
his neighbors last week. "I never learn"

Also had an argument in prison before admission
"I keep dredging up the past - she feels bad - I feel bad
- It's my fault"

SH
(H. 18th)

Imp

Delusional in MS - 2° to cannabis use
Psy & in mood although does not present as depressed
Man continue to monitor mood & MS. R Dept to depot 2x weekly
moves within hospital grounds only.

1/12/02 WR Dr Canavan

do H several voices - only some recognizable, much outside his head.
directed at him, screaming, nasty comments, general dirt - dirt.
no longer has idea of reference from TV - attributes this to
cannabis use.

used "alright" conflict team
sleeping with son wand

Plan

Enforce day-night routine.

Continue to assess all on ward.

Continue escorted passes.

Stop lorazepam PRN, continue haloperidol PRN, due depot depot 25mg weekly

from N/S

Leon has expressed ongoing "infatuation" with nursing student he met on ward
last year. He has not asked on this and denies he would contact her
or try to meet her.

off.

3/12/03

No sleep last night, of "racing thoughts"

lorazepam PRN discontinued yesterday
unpholone has hx of no effect

Plan

lorazepam 2mg nocte

haloperidol 5mg PRN

Abolter cistrix regularly

Leon has been less unstable / aggressive with her

Unescorted passes with bag grounds.

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5/12/03

Rh

Auto settled overall. When works daily. No MX problems.
Appears relaxed; undistressed.

Begin of agitation.

Slept well last night. Wants temporary disoriented "o"
wed to nurse of "relativist doesn't work".

S @ note is in matrix

in O: entourage reachie
B: "OIC"

getting on better with nurse, "trying to forget the past"
hasn't felt annoyed / angry "ever" for past few days

T of TD, not delirious / paranoid content elevated.
"idea of reference from radio"

Heard voices last night - people "singing"
from a distance.

Unsettled TAP.

I hopes he will continue to improve and be able
soon? next week.

happy to stay in hosp.

Addressing to paves within hosp grounds

Imp

MS improving

WT - please contact ? enquired home for several
hours at wife.

Unsettled paves within hosp - grounds off
C/O 15/11/03

8/12/03

NR Dr Cavanagh

Little sleep on Sat night - V. unstable + up + down on Sun
Slept well last night. - no AH in bed last night.

Admits to instability + down yesterday - planned to apologise

No AH during the day.

No evidence of FTD

Plan to stay in pt for ~ 2 hrs longer until MS much better

Panes next up to see son (short stay period) as long as
MS continues to improve after mid-week - repeat present.

GI rupture 15mg note.

Not deferrable.

10/12/03

Noted instability in the evening

Later in afternoon, brightens + becomes warmer in affect + interaction

OT to engage.

Now haloperidol med + good effect, less frequently.

Has slept well for last 3 nights

Dec next week?

Panes as wishes.

11/12/03

Asking for o/n pass Sat → Sun

OE Pleasant, warm affect
med O + S entourage sleeping OK
° FTD not defined

Denies any further medical AH

States his mum agrees + his desire to go home o/n for
his son's visit this w/e. Son normally stays with his mum
when he visits. Pls o/n pass, Notify cot. th

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15/12/03

Dr. C. Canavanagh

Returned from on pan yesterday

Concern that he may ~~be~~ not be improving as he was last week.

Nurses report: aggressive thoughts about ex-wife and anger in mother.

Responding verbally to Television last night

Paranoid ideas about "people after him/worshipping him"
~~He~~ Believed his ex-wife was upstairs in his house a neighbor

Thinks his pan went well

Denies ideas of reference from the TV

Admits to slight instability

Sleeping well

Plan

Add a oral anti-psychotic. — Happened 2mg qid
the over next few days

Dr. Canavanagh will arrange to meet in room
with Leon's consent.

th

16/12/83

RW

Up till 3am last night. - i chatting i another pt.

Also up during the night - hearing people talking - "Att
feeling a bit low

"- angry i mum - "she has her own agenda" "wants to control my life"
"she likes to torture me" "I've asked her not to visit - she's mean to me
wants to want to punch her, but knows better than to do that
"I'll end up injured!"

Says he still has the samurai swords at home

- he was collecting them for interest

writing a book about ninjas

doesn't plan to use them

"Why do you ask?"

Explained that I had to ask him of his expressed aggressive
thoughts towards his mum.

Wonders about o/N pan at Wle

Plan

RW later this week - Tri

No o/N panes at present.

Short unmarked panes in hosp. grounds only.

psychiatric sv is forced hostility to mum.

Explained panes to her so that it will do
him later this week - OK with this

LH
(H/15H/0)

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16/12/03

wants to go home for o/n pass this week.

Tired of being on the ward

feels people are making fun of him

- can't state any specific incidents

Denies any intent to harm his men.

Swords are for collection only

Denies any Att presently except for

? hypnagogic Att last night.

NOT detainable

Accepts advice to stay in-pt.

Agrees to o/n pass on Thurs - back for R/U Friday
and Sun night son is visiting

Dr. Dr. Corvagh

HL

(Ho 1810)

17/12/83

Rlv of plan

0/N pass Thu - Fri and Sun - Mon

Slept OK last night

Concise needs as per kendax - dept approval 250g weekly
- help needed on reg.

Not detainable

Sh.

18/12/83

Unpleasant pass

Dennis any and my hellmouth

Slept OK - woke up in pain but not distressed about this

Also met man last night - got on OK

wants to go home doesn't like being on the ward

Would be OK to go on w/e pass Fri to Mon for ch &

Sh.
(Ho, S/Ho)

D.O.B 17/3/75

GP: DR TAYLOR

INVERKEITHING
MEDICAL CENTREConsultant: DR Cavanagh
CPN: Tom ShawP.C: Over dose

Back ground: - Schizophrenia
 - Borderline personality dis.
 - Known to psych team.
 - Previous admission to W2
 - on Depexol weekly depot.

HOPI:

Presented to A&E with hwy overdose of Lorazepam ~ 250mg
 in total ~ 10 tablets this afternoon.
 Claims he heard voices asked him to commit suicide
 and die (told you) "It's not worth living" you'd better
 off dead".

Responded to these sounds, shouted at them with (F)
 word.

Patient claims that he is "sick of living".

Semi impulsive act. No planning.

planned to take his life away.

Feed up with life.

Didn't leave any suicidal notes or will.

NOT planned. Semi impulsive response to the voices.

Neighbours were laughing at him (as he thinks).

took paracetamol as well 8-10 tablets

phoned DHS 24 → send him an ambulance. → A&E

Claims that he was trying to take the rest of the
 tablets - doesn't know why he didn't take them.

Still have the thought of killing & harming him self.

Doesn't regret it, wish he'd done it and he thinks
 he would die anyway.

Not hearing voices at the moment.

No trigger tonight. (but sick of living is general)

Still have intention to die but "he hope not
 as he thinks he cannot control it.

missed your depot x2 over the past 2 weeks
 as he was sleeping all day.

11/3/07

- Sleep 12 hrs day sleeping is very interrupted over night.
- Very poor appetite.
- Good concentration + energy.
- His grandmother died 5 weeks ago - affect him badly
- phones w2 for ability relieve (talks to staff).
- Denies taking any drugs tonight / or any alcohol
- Have paranoid ideas about people (thinks people broke into his house and broke few stuff.)

PHx: On Depot Cleprol weekly depot

- NITRAZEPAM at night.
- Diagnosed as schizo affective / personality disorder (borderline).
- Known to our psych services.
- Under DR Conway last seen him 2 months ago.

Seen Dr. Lehany. Haldane house. → 2 weeks back.
resumed Depot obs.

Medical Hx: Eczema.
Asthma.

Social Hx: - Lives alone for the past 5 years

- Bottom flat (Convent)
- Unemployed.
- Incapacity DLA Benefits.
- Smoker 40/day.
- occasional drinks.

Forensic Hx: - Been in trouble with police because he punched his mother in the nose.
- Been to court for that.

Personal Hx: Born in Manchester.

- Primary + Secondary school (Edinburgh)
- Never been to uni.
- No qualifications.
- Been through few jobs.
- Worked as laborer 7 years back.
- Now unemployed.

D.O.B 17/3/75

Mental State examination

A: Casually dressed. average build.
average self care.B: odd behaviour, paranoid looking through the window
from time to time.- Responded to voice one but I couldn't understand
what he said.

- Co-operative.

- Good eye contact.

- Good communication.

T: Still having thought of suicide / self harm.

- NO FTD.

M: Very low. Affect: restricted times
reactive at times.P: Sees black and white people in the room.
Speaks to him and disappear after a sudden.

S: Normal speech (tone, rhythm, volume)

C: Intact.

Insight: poor insight.

Phys: Examination.

- Oedema o Tachycardia o Palpitations.

- No distress or in any pain.

Chest: clear good at both sidesAbdomen: soft

o Masses

o Rebound

o Guarding

o Rigidity

Neurology: Cranial Nerves (N)

Cerebral signs (N)

No visual problems

A/S

pupils equal in size + reactive to light

- Power / sensory / tone all $\odot$
- Reflexes ~~NOT~~ done
- Coordination $\odot$ Gait $\odot$ Speech $\odot$
- Fundoscopy $\rightarrow$ NOT done.

- (P) - Needs admission to ^{Rothers} ward.
- Eventually found a bed (last bed) in Rothers ward.
 - Kardex
 - physical exam
 - DMW Rothers
 - SHO informed $\rightarrow$ tried to phone again $\rightarrow$ beeped $\rightarrow$ couldn't get through.

- Paracetamol 0.18 (below Rx line.)
- Salicylate < 0.2
- U/E: Na 138
K 3.9
Ur. 3.7
Cr. 87
Albumin 46
- LFTs - Not back till tomorrow
- ECG $\rightarrow$ Normal
- Medically cleared by SHO & SHO.

L. Mikhali
T. Mikhali's
SHO
2296

L. Mikhali
T. Mikhali's
SHO
2296

12/3/09

Review Dr. Barton -

Told that everything was 'getting on top of him'

Called @ 10/15 24 himself.

Felt that he may damage his liver by taking op and didn't want this to happen.

Felt that someone is coming into his house and taking things. Thinks it may be his neighbours. 'to wind him up' as he was a ~~pre~~ drug user previously.

Missed his last 2 depots as he was spending all the time taking a girl called 'Susan'. ~~Felt asleep~~
Slept 7:4 late in the day and so missed his depot.
Is not taking anymore as ~~he~~ he received a bill for £500 for his phone.

Was previously on Gilaprom, not on it now.

Has taken overdoses in the past, 'creedly' in times of stress. Usually once every 3 months.

Gets Samaritans almost every night.

Afraid he would wake up and find his throat slit by old enemies because he knows secrets about them, so they consider him a threat.

Relationship to parents 'up and down'.

Parents split up. Dad in Manchester. Gets on well to him.

Lives alone. Flat. Does not like being alone.

Living like this for 5 yrs

Lived in Airdrie Homelers Accommodation 5 yrs ago

At the time he was in a relationship to lasted 3-4 yrs. They broke up and she kicked him out. Was assaulted in the Homelers Hostel.

Before that he was in Penumbra in sheltered Accommodation.

Doesn't drink any alcoholic or any illicit

Drug use.

Sees support worker twice a week.

Sees CPN once a week.

Richmond comes in 4 times a week.

Finds weekends and nights the most difficult.

Sees Dr. Cavanagh every 3 months.

Last admission 2 yrs ago.

Does not feel that he's dept help.

Wanted like something to stop hallucinations.

Hears someone talking in his ear at least once or twice a day - sometimes good, sometimes bad that talks to him.

Sees things - people appearing and disappearing in his room - black and white, not clear, anything of the day in his house.

Paranoia - Feels everyone is out to get him and are conspiring at him. Cannot be sure if this is true.

Thinks people laugh at him because he is an 'idiot', as he hasn't achieved anything worthwhile.

Has one son 8 yrs ago who lives in his men. Sees him twice a month. Son is slightly depressive.

Plan -> To obtain a medical note from Dr. Cavanagh.

Observation, action, assessment.

12/3/07

12/3/07 I reviewed 12 obs of notes, from his case & largely personal issues

self esteem poor "feel like village idiot"

"picked on" "vulnerable"

Reluctant coping strategy of overclosing

— OD's 2 every 3/12

12/3/07

~~been better~~

Not overly psychotic
 not overly depressed, not actively suicidal
 feels lonely, is single, occasionally
 accommodated, there & 5 yrs

last 6 yrs → Resurgence
 lots of community supports

Missed depot x $\approx \frac{2}{5}$
 as texting girl all her life
 got bill of fraud - 500

Plan:

Do not appear to be any mental
 issues

Keep some medication

here to learn

[Signature]
 10/1/07

13/3/07

Medical records still not arrived
 left message for Dr. Conroy to
 get in touch 02/12/3/07

14/3/01 Stg review -

Leonard dept Today -

Has generally been feeling better. Need much brighter.
Has been observed to singing, humming to himself.
Still believes that people are laughing at him, ~~in~~ in fact
woke up last night thinking that he heard others in the
room laughing at him. Now he is not sure if this was
a dream.

Sleep still not as good.

Appetite good. Eating well. Pleased & appropriate at interviews.
Denies any continuing thoughts of self harm.

Notes still accepted.

P con -> Guidelines as present

Stg

15/3/01 WOK Dr. Bulson -

Comes across as very unhappy.
They are not ~~so~~ satisfied w his package of care even
though it is good package of care.
Symptoms of anxiety seen.
His CPN has felt that there was an increase in
his paranoid ideation.

Interview -

Appears brighter.

Says he has felt dizzy at times.
Explained to him that his problems are long standing. No
new issues.

Leon agrees to this.

Happy to have gotten his depot.

Says his CPN once a week on a Friday.

Explained to him that being in hospital is not beneficial
and would be better to discharge him.

Leon agrees to this.

Is going to a party tonight organised by his mum.

15/3/07

Plan: No D/C meds as he has them at home.

Also by CPW Tom Short, to inform of Leon's discharge.

To inform his mother of D/C.

To be given Nitrazepam for tonight.

D/C today.

CAF

15/3/07

Spoke to Dr Cameron
agrees by standing issues
agreeable to discharge

No evidence of acute psychosis

Spoke to Leon's mum & phone

Discussed the situation

She agrees also with discharge

Discharge today

to be given one night med only
10 mg of 2 of 00mg of

Nursing staff to inform Tom Short of

D/C + ? review tomorrow

30/12/07

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Leon
Grattan
17/3/75

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01/02/08

YTHO.

patient brought up by WSCOT for assessment

Dx Schizophrenia

emotionally unstable personality disorder Schizotypal

WSCOT

Attended Home to administer depot.
concerns raised by team over weekend, patient reported
two 8 co-codamol tablets. Was advised to attend
A&E at that time, however did not.

When used by team today over 40 dergartey +
command suicide hallucinations; last night took 8
further co-codamol.

Compliant at depot.

Team cannot identify any triggers leading to
presentation.

Seen ->

"I've not slept all night"

"voices, hallucinations you name it"

Ongoing for 3-4 months, ↑ voices + intensity is ~~low~~ 05/01/08

"window got smashed"

Unrec who or why this was done

"Voices, overdrive, paranoia"

Voices → "get back to your own species"

"wouldn't touch you with a hot stick"

2nd person elegantly, one more, one woman
but voices.

"I think it actually happened"

Voices occur "just after overdrive" when "kind of stressed out"

Both overdrive on Saturday 12 co-codamol, "side of living"
no preplanned, no note. precipitated by "loneliness"

Argument with mother & father precipitated; "not had a
partner for 7 years" Called Richmond fellowship,
told community outreach team "fine"

Took 8 tablets "Dad called me a piece of dirt"

Thursday, 8 co-codamol, ~~didn't tell~~ called Samaritans
"Coarse I called the Samaritans 'I'm not daft'"

Last OD last night, 8 paracetamol, took all in one
go 2 at a time, every 2 hours; some today.

so essentially 1g every 2 hours. "Intention of dying"

Although no current suicidal ideation or plan, would not
end life because of his son.

"Frustrated relationship between me and my father"

"Paranoia" →

voices make him "paranoid", once who this is, wants to
hurt him. Unrec how, vague.

Mood "low" 3/10, sleep → 3-4 hours a night, "years", appetite,
1 meal a day, no interest in "years", memory poor "years", concentration poor
energy levels → poor last 2 1/2. Envyment → negative.

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Lean
Gratton
17/03/75

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past hx
Under CUFOT. Long hx, prob under child & services.
on depot Last self harm, after Grandmother death 1 year ago.
Dx schizophrenia at 18, IPCC in past.
med hx none
medication
alprazolam 50mg weekly
diazepam 10mg OD max
nitrazepam 100mg nocte → coped with CUFOT

family hx

```

graph TD
    P1[ ] --- P2[ ]
    P1 --- C1[ ]
    P1 --- C2[ ]
    P1 --- C3[ ]
    C3 --- C3a[ ]
    C3a --- C3b[ ]
    
```

last sw "heart" ago
legit,
sees once a month per 3 hours,
supervised access

Aunts suffer from "agoraphobia"

Drugs + ETOH
no ETOH, denies illicit drug use, smokes "alot."
hx of misuse of benzos + LSD in past.

Forensic hx
Att mother + her partner, "few yrs now" → domestic → no
charges pressed. Denies conviction.
tends to be inappropriate with female staff? Disobedience in past

Part 1hr

Issues of abuse at child as documented

David and patient, does not wish to revisit childhood

Ben in Manchester, brought up in Fife, aged 15 mother would have
+ his sister has been sexually abused by father, abuse led to estrangement with
mother. Care homes 15-16 w/ drug use.

Conent Social

Living alone, could, living alone. No friends or family
nearby. Dest of £10,000. No contact relationship.
Challenged

MTE A+B → Caucasian gentleman, could, clever, good rapport, good
EC, care, but of his poetry and a pen.

S → (N) rate, with volume

M → "O" behaviour
"5" low, 3/10

T → Vague paranoid ideation 2° to hallucinations, although
not of psychotic intensity, concern, more concerns.

No contact suicidal ideation but does if goes home
likely will act against himself again

OTI/WI/B + passing + FTD

No homicidal ideation or plan

P → 2nd person auditory hallucination, patient has thought
that these are "voices" but are "real", derogatory + command
suicide. Heard → flashes of light → in night always present

C → full

I → unsure nature of problem, David trigger, willing for
admission for shorter assessment.

Imp → likely crisis associated with relationship dysfunction,
mirror UD, and always precipitated by discord and need help
afterwards. However in view of his some underlying mental illness,
a period of assessment.

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O/E. Jtly m clear, in no disten

BP 126/82, P 72 bpm reg, T 36.2°C

ENT I+II to = m n.

AS do ☐ sut = m 15 (R)

resp ~~DO~~ good A/E & distally
no creps or wheezes

neuro - fully intact

in view of paracetamol use

Stands for FBC, U+E, EFT, coag, paracetamol, 1 delegate & 1 scribe.

(P) Ask on call Dr to check stands;
admit informally;
general for
PRN reg'd drng.

17/03/75
(SH)

2/2/8

2PM

SHO ON CALL FOR INSTRUCTIONS

- ABP blood result by nursing staff
- results not on computer this morning —> calculated labs
- > sample not analysed + taken to Victoria
- > results came back normal FBC, U+E, LFTs.
- Paracetamol level not ↑ enough for tx with NAC.


(Leon)

07/02/08 W/c Dr Carragh

"Voices"

Derrygally.

hx of overdoses revisited,
sleep poor, slept well in hospital

"not as depressed, not lonely"

Argument with father on Friday.

Mother visited yesterday, "arguing all the time"

phone mother after overdose last week

"Been hallucinating a lot" → "cars screaming at people"
"lanes running."

Phoning Samaritans rather than mother at night →
mother becomes annoyed, feels unsupported

Downed T depot.

(P) T flupentixal ~~6mg~~ 10mg 1/2.

↓ diazepam 6mg

// 10/11/08/16
(mm)

05/02/07 YHTO

Reviewed at Dr Carragh

Rx revisited;

explored event leading up to admission, 2 1/2 ago difficulties with
girl he became friendly with, son in her shop was abusive towards him
and asked him not to return. He has not seen this woman since.

Arguments with father.

patient disconcerted these events rather difficulties w/ neighbour; swastika painted
on wall near flat sees this related to him, disagreement with gangs in
Edinburgh.

Ongoing concern of neighbour upstairs, although arguing for 2 years, without change
Neighbour threatening towards him, claims he is a drug dealer and has
dispute with him in particular. Although personality clear, not delusional, no
evident psychotic symptoms with these concerns. Would not act against
neighbour.

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More settled in hospital, no voices since admission.

Mood much improved, sleeping well.
laughing and joking.

Can have suicidal ideation, no plan. This is a chronic feature
for 7 years related to lack of relationship although has interest
in his writing, attempting to get published and engaging in WFCOT
groups

Denies illicit drug use, adamant would not do drugs and might into
this.

Consistently low, no homicidal ideation towards others despite interpersonal
difficulties. Although chronic suicidal ideation no intent to act and trigger
for the future.

Patient D/W Dr. Carcraigh → given permission to D/W mother

(P) D/C tomorrow

T WFCOT support

OPD only

help help w/ abuse issues

ASH/ASH
(5th)

FIFE PRIMARY CARE

Referral to: HILLVIEW DAY HOSPITAL

Date: 21.2.02

NAME: LEON GRATTON DATE OF BIRTH: 17-3-75

ADDRESS: 85 SPITALFIELD ROAD
INVERKEITHING

TEL NO: (416833) - 07762602059 - 420856 MURRAY
07762794260

G.P. Dr. GARMAN CONSULTANT Dr. EDWARDS

REASON FOR REFERRAL:

Routine ☒ Urgent ☐

Paranoid thoughts, Anxiety, Preoccupied by past events - ex partner
Isolated in flat. Occupies time writing "horror" stories and
watching DVDs. Very poor motivation. Previous history - psychotic episode
Disturbed sleep pattern.
? Dietary intake lacks motivation to cook
Referral for assessment - ? Anxiety management, ? Men's group

SOCIAL CIRCUMSTANCES:

lives alone, mother likes locally frequent conflict with mother.
3 year old son Darren, - sees via mother weekly -> fortnightly little
interaction: son lives with mother ? Kilsyth.

1st app. 12/3/02
1st app. 15/3/02 10.15 AM 11 AM

ADDITIONAL BACKGROUND INFORMATION INCLUDING PRESCRIBED MEDICATION, ANY RISK FACTORS PRESENT OR INVOLVEMENT OF OTHER SERVICES:

Present medication olanzopine 10mg, hustral.
? compliance.

(Due to see Dr. Edwards 6/3/02 2.30pm. If any staff available to attend.)

Discussed between Resley Tweede Referrer. Mike Kelly Recipient

Appointment date and time

PE meeting 25/2/02 ✓

Sheet No.

[illegible]

NAME OF PATIENT
P. L. L.

UNIT No. _____

CONSULTANT

WARD 20THS

MEDICINE RECORDING SHEET

KEY
Ⓐ DRUG REFUSED
Ⓑ PATIENT ABSENT

Date	REGULAR PRESCRIPTIONS												DEPOSIT INJECTION				AS REQUIRED				COMMENTS ON DISCREPANCIES																				
	8.00				13.00				18.00				22.00				Intls					Code				Time				Intls				Code				Time			
	Intls	Code	Time	Intls	Code	Time	Intls	Code	Time	Intls	Code	Time	Intls	Code	Time	Intls	Code	Time	Intls	Code		Time	Intls	Code	Time	Intls	Code	Time	Intls	Code	Time										
11/5/7																																Ⓐ DUE 18/5/7									
17/5/7																																Ⓐ DUE 25/5/7									
26/6/7																																Ⓐ DUE 1/6/7									
31/5/7																																									
1/9/7																																Ⓐ DUE 4.6.07									
8/6/04																																Ⓐ DUE 15-6-7									
15/6/7																																Ⓐ DUE 22-6-7									
25/6/7																																Ⓐ DUE 1/6/07									
5/7/7																																Ⓐ DUE 12-7-07									
12/7/7																																Ⓐ DUE 19-7-07									
19/7/7																																Ⓐ DUE 26-7-07									
26/7/7																																Ⓐ DUE 2/8/7									
3/8/7																																Ⓐ DUE 9/8/7									
10/8/7																																Ⓐ DUE 17/8/7									

NB - A NEW RECORDING SHEET MUST BE TAKEN EACH TIME A PRESCRIPTION SHEET IS CHANGED
PRESCRIPTION SHEET NO.

KEY
☒ DRUG REFUSED
☒ PATIENT ABSENT

MEDICINE RECORDING SHEET

Date	REGULAR PRESCRIPTIONS												OTHER TIMES						DEPOT INJECTION		AS REQUIRED				COMMENTS ON DISCREPANCIES																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																							
	8.00		13.00		18.00		22.00		Code		Time		Code		Time		Code		Time																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																													
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24/3/04																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																

PRESCRIPTION SHEET (USE BLOCK LETTERS)

Sheet No.

START DATE		DISCONTINUED		REGULAR MEDICINES		DOSE	METHOD OF ADMINISTRATION	TIME OF ADMINISTRATION					PRESCRIBER'S SIGNATURE
Date	Signature	Date	Signature										
A								0800	1300	1800	2200	Other times	
B													
C													
D													
E													
F													
G													
H													
I													
J													
K													
L													
M													
N													
O													
P													

START DATE		DISCONTINUED		AS REQUIRED MEDICINES		DOSE	METHOD OF ADMINISTRATION	INDICATION	MAXIMUM FREQUENCY	PRESCRIBER'S SIGNATURE
Date	Signature	Date	Signature							
R	12/3/67			LOBAZEPAM	2mg	P.O.	Asitaban	6mg 12hr		
S	12/3/67			LOBAZEPAM	2mg	P.O.	Asitaban	6mg 12hr		
T	12/3/67			HALOPERIDOL	5mg	P.O.	Asitaban	15mg 24hr		
U	12/3/67			HALOPERIDOL	5mg	I.M.	Asitaban	15mg 24hr		
W										
X										
Y										
Z										

START DATE		DISCONTINUED		DEPOT/INJECTIONS		DOSE	FREQUENCY	PRESCRIBER'S SIGNATURE
Date	Signature	Date	Signature					
1								
2								
3								
4								

ONCE ONLY MEDICINES AND PREMEDICATION				
DATE	MEDICINE	DOSE	METHOD OF ADMINISTRATION	TIME

TICK IF PRESCRIBED ON THE FOLLOWING SHEET		LIST OF MEDICINES TO BE AVOIDED DUE TO PREVIOUS REACTION		REFERRED DATE
	✓	MEDICINE		

NAME OF PATIENT Leon Crafton

AGE 311 DATE OF BIRTH 12/12/7

UNIT No.

CONSULTANT

WARD

KEY
 DRUG REFUSED
 PATIENT ABSENT

MEDICINE RECORDING SHEET

[illegible]

NAME: Leon Gratton UNIT No: W.D. Rothel

MEDICINE RECORDING SHEET

Date	REGULAR PRESCRIPTIONS												DEPOT INJECTION				AS REQUIRED				COMMENTS ON DISCREPANCIES							
	8.00			13.00			18.00			22.00			Intls		Code		Time		Intls			Code		Time		Intls		
	Intls	Code	Time	Intls	Code	Time	Intls	Code	Time	Intls	Code	Time	Intls	Code	Time	Intls	Code	Time	Intls	Code		Time	Intls	Code	Time	Intls		
6/6/06																												I could not attend today due 20/6/06
20/6/06																												due 20/6/06
4/7/06																												due 4-7-06
5/7/06																												due 5/7/06
1/8/6																												due 1/8/6
1/8/6																												due 1/8/6
1/8/6																												due 1/8/6
15/8/6																												due 15/8/06
17/8/06																												due 17/8/6
17/8/06																												due 17/8/06
28/8/06																												due 28/8/06
12/9/06																												due 12/9/06
24/9/06																												due 24/9/06
9/10/06																												due 9/10/06

NAME: LEON GRATTAN UNIT No: WARD: COT

KEY
DRUG REFUSED

Date	REGULAR PRESCRIPTIONS										OTHER TIMES				PATIENT ABSEN				COMMENTS ON DISCREPANCIES											
	8.00		13.00		18.00		22.00		Code	Time	Intls	Code	Time	Intls	Code	Time	Intls													
	Intls		Intls		Intls		Intls											Code		Time	Intls	Code	Time	Intls						
23/10/06																			1 R											due 20/11/06
6/11/06																			1 TS											due 20/11/06
28/11/06																			1 TS											due 4/12/06
4/12/06																			2 OS											due 18/12/06
13/12/06																			2 TS											due 27/12/06
18/12/06																			2 TS											due 28/12/06
4/1/07																			2 TS											due 18/1/07
18/1/07																			2 TS											due 23/1/07
23/1/07																			2 TS											due 6/2/07
2/2/07																			2 TS											due 8/2/07
11/2/07																			2 TS											due 16/2/07
22/2/07																			3 OS											due 1/3/07
1/3/07																			1 TS											due 6/3/07
6/3/07																			2 TS											due 8/3/07
18/3/07																			2 TS											due 23/3/07
23/3/07																			2 TS											due 6/4/07
2/4/07																			2 TS											due 8/4/07
11/4/07																			2 TS											due 16/4/07
18/4/07																			2 TS											due 23/4/07
23/4/07																			2 TS											due 6/5/07
2/5/07																			2 TS											due 8/5/07
11/5/07																			2 TS											due 16/5/07
18/5/07																			2 TS											due 23/5/07
23/5/07																			2 TS											due 6/

WARD:

Sheet No.

START DATE	DISCONTINUED		REGULAR MEDICINES	DOSE	METHOD OF ADMINISTRATION	TIME OF ADMINISTRATION					PRESCRIBER'S SIGNATURE	
	Date	Signature				0800	1300	1800	2200	Other times		
A												
B												
C												
D												
E												
F												
G												
H												
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O												
P												
START DATE	DISCONTINUED		AS REQUIRED MEDICINES	DOSE	METHOD OF ADMINISTRATION	INDICATION	MAXIMUM FREQUENCY	PRESCRIBER'S SIGNATURE				
9/4/6			HALOPERIDOL 5mg x 5					[Signature]				
5/4/6			VITAMINAM 5mg x 5					[Signature]				
T												
U												
W												
X												
Y												
Z												
START DATE	DISCONTINUED		DEPOT INJECTIONS	DOSE	FREQUENCY	PRESCRIBER'S SIGNATURE	TICK IF PRESCRIBED ON THE FOLLOWING SHEET		LIST OF MEDICINES TO BE AVOIDED DUE TO PREVIOUS REACTION			
1							✓		MEDICINE			
2												
3												
4												
ONCE ONLY MEDICINES AND PREMEDICATION												
DATE	MEDICINE	DOSE	METHOD OF ADMINISTRATION	TIME	PRESCRIBER'S SIGNATURE	GIVEN BY	GIVEN AT					
NAME OF PATIENT		AGE	DATE OF BIRTH	UNIT No.	CONSULTANT							WARD
[Signature]		21	17/1/55	CR102X77								

PREScription SHEET (USE BLOCK LETTERS)

Sheet No.

2

START DATE	DISCONTINUED		REGULAR MEDICINES	DOSE	METHOD OF ADMINISTRATION	TIME OF ADMINISTRATION				PRESCRIBER'S SIGNATURE
	Date	Signature				0800	1300	1800	2200	
A										
B										
C										
D										
E										
F										
G										
H										
I										
J										
K										
L										
M										
N										
O										
P										
START DATE	DISCONTINUED		AS REQUIRED MEDICINES	DOSE	METHOD OF ADMINISTRATION	INDICATION	MAXIMUM FREQUENCY	PRESCRIBER'S SIGNATURE		
Date	Signature									
R										
S										
T										
U										
V										
W										
X										
Y										
Z										
START DATE	DISCONTINUED		DEPOT INJECTIONS	DOSE	FREQUENCY	PRESCRIBER'S SIGNATURE	TICK IF PRESCRIBED ON THE FOLLOWING SHEET	LIST OF MEDICINES TO BE AVOIDED DUE TO PREVIOUS REACTION	MEDICINE	DATE
Date	Signature									
1										
2										
3										
4										

ONCE ONLY MEDICINES AND PREMEDICATION		DATE OF BIRTH		AGE	UNIT No.	CONSULTANT	WARD
DATE	MEDICINE	DOSE	METHOD OF ADMINISTRATION	TIME	PRESCRIBER'S SIGNATURE	GIVEN BY	GIVEN AT
17-11-03	Hydrocortisone	2mg	Oral	1840	<i>[Signature]</i>	SHARON	RMS
17-11-03	Hydrocortisone	2mg	Oral	1840	<i>[Signature]</i>	OR	2135
17-11-03	Zopacalone	15mg	Oral	1940	<i>[Signature]</i>	OR	2135
18-11-03	Hydrocortisone	2mg	Oral	0945	<i>[Signature]</i>	SE CL	0945

PREScription SHEET (USE BLOCK LETTERS)

Sheet No.

START DATE	DISCONTINUED		REGULAR MEDICINES	DOSE	METHOD OF ADMINISTRATION	TIME OF ADMINISTRATION				PRESCRIBER'S SIGNATURE	
	Date	Signature				0800	1300	1800	2200		Other times
A 07/11/03	07/11/03	df	MELATONIN	10mg	oral						
B 07/11/03	07/11/03	df	PERA 200mg	100	oral						
C 08/12/03	08/12/03		Zopiclone	15mg	oral						
D 05/12/03	05/12/03		Haloperidol	2mg	oral						
E											
F											
G											
H											
I											
J											
K											
L											
M											
N											
O											
P											

START DATE	DISCONTINUED		AS REQUIRED MEDICINES	DOSE	METHOD OF ADMINISTRATION	INDICATION	MAXIMUM FREQUENCY	PRESCRIBER'S SIGNATURE
	Date	Signature						
R 08/11/03	08/11/03		Symptomatic Relief Policy					
S 20/11/03	20/11/03		Haloperidol	5mg	oral	anxiety	4 times daily	
T 20/11/03	20/11/03		Haloperidol	2.5mg	oral	anxiety	4 times daily	
U 20/11/03	20/11/03		Haloperidol	2mg	oral	anxiety	4 times daily	
V 20/11/03	20/11/03		Haloperidol	2mg	oral	anxiety	4 times daily	
X 20/11/03	20/11/03		Dipiro-Base cream	1g	topical	dry skin	PRN	
Y								
Z								

START DATE	DISCONTINUED		DEPOT INJECTIONS	DOSE	FREQUENCY	PRESCRIBER'S SIGNATURE	TICK IF PRESCRIBED ON THE FOLLOWING SHEET	LIST OF MEDICINES TO BE AVOIDED DUE TO PREVIOUS REACTION	
	Date	Signature						REACTION	MEDICINE
1 28/11/03	28/11/03		Zuclopentixol	25mg	weekly (Mon)				
2									
3									
4									

NAME OF PATIENT

AGE

DATE OF BIRTH

UNIT No.

Dr. M. CONSULTANT

WARD 2

PREScription SHEET (USE BLOCK LETTERS)

Sheet No.

START DATE	DISCONTINUED		REGULAR MEDICINES	DOSE	METHOD OF ADMINISTRATION	TIME OF ADMINISTRATION					PRESCRIBER'S SIGNATURE
	Date	Signature				0800	1300	1800	2200	Other times	
A											
B											
C											
D											
E											
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G											
H											
I											
J											
K											
L											
M											
N											
O											
P											
START DATE	DISCONTINUED	AS REQUIRED MEDICINES	DOSE	METHOD OF ADMINISTRATION	INDICATION	MAXIMUM FREQUENCY	PRESCRIBER'S SIGNATURE				
R 4/4/13		20p.cloane	7.5mg	ORAL	WINDGUT	x 1 in 24 hrs	JSa...				
S											
T											
U											
V											
W											
X											
Y											
Z											
START DATE	DISCONTINUED	DEPOT INJECTIONS	DOSE	FREQUENCY	PRESCRIBER'S SIGNATURE	TICK IF PRESCRIBED ON THE FOLLOWING SHEET	LIST OF MEDICINES TO BE AVOIDED DUE TO PREVIOUS REACTION	REFERRED DATE			
1						✓					
2											
3											
4											

ONCE ONLY MEDICINES AND PREMEDICATION		METHOD OF ADMINISTRATION		PRESCRIBER'S SIGNATURE		GIVEN BY		GIVEN AT	
DATE	MEDICINE	DOSE	TIME	PRESCRIBER'S SIGNATURE	GIVEN BY	GIVEN AT			

NAME OF PATIENT	AGE	DATE OF BIRTH	UNIT No.	CONSULTANT	WARD
					2

KEY
 **DRUG REFUSED**
 **PATIENT ABSENT**

KEY
 DRUG
 PATIENT

LOC 792
R 44 1500174 A

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NB - A NEW RECORDING SHEET MUST BE TAKEN EACH TIME A
PRESCRIPTION SHEET IS CHANGED
PRESCRIPTION SHEET No.

KEY
Ⓐ DRUG REFUSED
Ⓑ PATIENT ABSENT

FIFE HEALTH BOARD
MEDICINE RECORDING SHEET

Date	REGULAR PRESCRIPTIONS												DEPT. INJECTION				AS REQUIRED				COMMENTS ON DISCREPANCIES													
	8.00			13.00			18.00			22.00			Intls			Code			Time			Intls			Code			Time			Intls			
	Intls	Code	Time	Intls	Code	Time	Intls	Code	Time	Intls	Code	Time	Intls	Code	Time	Intls	Code	Time	Intls	Code		Time	Intls	Code	Time	Intls	Code	Time	Intls	Code	Time			
3/11/05																																	Ⓐ due 10/11/05	
10/11/05																																	Ⓐ 10/11/05	
15/11/05																																	Ⓐ 13.11.05	
24/11/05																																	Ⓐ 24.11.05	
29/11/05																																	Ⓐ 29/11/05	
1-12-05																																	Ⓐ 1-12-05	
6-12-05																																	Ⓐ 6-12-05	
15/12/05																																	Ⓐ 15/12/05	
20/12/05																																	Ⓐ 20/12/05	
29/12/05																																	Ⓐ 29/12/05	
5-1-06																																	Ⓐ 5-1-06	
13-1-06																																	Ⓐ 13-1-06	
28-1-06																																	Ⓐ 28-1-06	
28/1/06																																	Ⓐ 28/1/06	
27/1/06																																	Ⓐ 27/1/06	

NAME: LEON GRATTAN

UNIT No:

WARD:

KEY
 DRUG REFUSED
 PATIENT ABSENT

FIFE HEALTH BOARD
 MEDICINE RECORDING SHEET

Date	REGULAR PRESCRIPTIONS						OTHER TIMES						DEPOT INJECTION			AS REQUIRED			COMMENTS ON DISCREPANCIES		
	8.00	Ints	13.00	Ints	18.00	Ints	22.00	Ints	Code	Time	Ints	Code	Time	Ints	Code	Time	Ints	Code		Time	Ints
25/1/05																					
11/3/5																					
9/8/5																					
11/4/05																					
18/6/05																					
29/8/5																					
2/9/5																					
8/9/05																					
21/4/05																					
29/9/05																					
6/10/5																					
13/9/5																					
29/6/5																					
24/10/05																					

NAME: Leann Curran

UNIT No:

WARD: COT

PREScription SHEET (USE BLOCK LETTERS)

Sheet No:

START DATE	DISCONTINUED		REGULAR MEDICINES	DOSE	METHOD OF ADMINISTRATION	TIME OF ADMINISTRATION					PRESCRIBER'S SIGNATURE	
	Date	Signature				0800	1300	1800	2200	Other times		
A												
B												
C												
D												
E												
F												
G												
H												
I												
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L												
M												
N												
O												
P												
DISCONTINUED	Date	Signature										
START DATE			AS REQUIRED MEDICINES	DOSE	METHOD OF ADMINISTRATION	INDICATION	MAXIMUM FREQUENCY	PRESCRIBER'S SIGNATURE				
R	22/8/5		ORPHENDRINE	PO	50mg.	EPSTE	UP TO TABS					
S												
T												
U												
W												
X												
Y												
Z												
DISCONTINUED	Date	Signature										
START DATE			DEPOT INJECTIONS	DOSE	FREQUENCY	PRESCRIBER'S SIGNATURE						
1												
2												
3												
4												
ONCE ONLY MEDICINES AND PREMEDICATION												
DATE	MEDICINE	DOSE	METHOD OF ADMINISTRATION	TIME	PRESCRIBER'S SIGNATURE	GIVEN BY	GIVEN AT					
NAME OF PATIENT								CONSULTANT	WARD			

NAME OF PATIENT

AGE

DATE OF BIRTH

UNIT No.

CONSULTANT

WARD

KEY
DRUG REFUSED
PATIENT ABSENT

MEDICINE RECORDING SHEET

Date	REGULAR PRESCRIPTIONS												OTHER TIMES				DEPOT INJECTION				AS REQUIRED				COMMENTS ON DISCREPANCIES						
	8.00		13.00		18.00		22.00		Ints		Code		Time		Ints		Code		Time		Ints		Code			Time		Ints			
	Ints	Code	Ints	Code	Ints	Code	Ints	Code	Ints	Code	Ints	Code	Ints	Code	Ints	Code	Ints	Code	Ints	Code	Ints	Code	Ints	Code		Ints	Code	Ints	Code		
11/12/03																															
12/12/03																															
13/12/03																															
14/12/03																															
15/12/03																															
16/12/03																															
17/12/03																															
18/12/03																															
19/12/03																															
20/12/03																															
21/12/03																															
22/12/03																															

Discharge
Depot note due
22/12/03
e.g. 1100 SNG

DMS oncoming

Discharge, next due
on 21-12-03

NAME: LEON GRATTON UNIT No: F5153833 WARD: Two

KEY
 Ⓐ DRUG REFUSED
 ⓐ PATIENT ABSENT

KEY
 Ⓐ DRUG REFUSED
 ⓐ PATIENT ABSENT

(MR) 57

NB - A NEW RECORDING SHEET MUST BE TAKEN EACH TIME A
 PRESCRIPTION SHEET IS CHANGED
 PRESCRIPTION SHEET No.

KEY
 A DRUG REFUSED
 B PATIENT ABSENT

MEDICINE RECORDING SHEET

Date	REGULAR PRESCRIPTIONS												OTHER TIMES				DEPOT INJECTION				AS REQUIRED				COMMENTS ON DISCREPANCIES					
	8.00		13.00		18.00		22.00		Intls		Code		Time		Intls		Code		Time		Intls		Code			Time		Intls		
	Intls	Code	Intls	Code	Intls	Code	Intls	Code	Intls	Code	Intls	Code	Intls	Code	Intls	Code	Intls	Code	Intls	Code	Intls	Code	Intls	Code		Intls	Code	Intls	Code	
1/9/03																														(L) side n. x 8/9/03
3/9/03																														(L) side
15/9/03																														(R) side
22/9/03																														(L) side
29/9/03																														(R) side
6/10/03																														(L) side
12/10/03																														(R) side
20/10/03																														(L) side
27/10/03																														(R) side
4/11/03																														(L) side
10/11/03																														(R) side
17/11/03																														(L) side
24/11/03																														(R) side
																														(L) side

NAME: LEON GRANTON UNIT No: WARD: COT

KEY
 Ⓐ DRUG REFUSED
 ⓐ PATIENT ABSENT

MEDICINE RECORDING SHEET

[illegible]

Sheet No.

START DATE	DISCONTINUED		REGULAR MEDICINES	DOSE	METHOD OF ADMINISTRATION	TIME OF ADMINISTRATION						PRESCRIBER'S SIGNATURE	
	Date	Signature				0800	1300	1800	2200	Other times			
A 19-3-02 18.3	M.H.		Olanzapine 15mg										M.H.
B 17-3-02			Lithium Salts 0										M.H.
C 18-3-02 21.3.02 M.H.			Olanzapine 15mg										M.H.
D 21-3-02 25-3-02 M.H.			Olanzapine 15mg										M.H.
E 27-3-02 29/3/02			Naloxone 0										M.H.
F													
G													
H													
I													
J													
K													
L													
M													
N													
O													
P													
R 17-3-02			AS REQUIRED MEDICINES	DOSE	METHOD OF ADMINISTRATION	INDICATION	MAXIMUM FREQUENCY	PRESCRIBER'S SIGNATURE	TICK IF PRESCRIBED ON THE FOLLOWING SHEET	LIST OF MEDICINES TO BE AVOIDED DUE TO PREVIOUS REACTION	REFERRED DATE		
S 17-3-02			Zephalin 7.5mg			Agitation, as required up to T.D.S. m.d.l.	As needed	M.H.					
T 17-3-02			Haloperidol 5mg			Agitation, as required up to 4mg in 24 hours m.d.l.	As needed	M.H.					
U 10/3/02			Olanzapine 15mg			Agitation, as required up to 4mg in 24 hours m.d.l.	As needed	M.H.					
V													
X													
Y													
Z													
1			DEPOT INJECTIONS	DOSE	FREQUENCY	PRESCRIBER'S SIGNATURE							
2													
3													
4													
ONCE ONLY MEDICINES AND PREMEDIATION													
DATE	MEDICINE	DOSE	METHOD OF ADMINISTRATION	TIME	PRESCRIBER'S SIGNATURE	GIVEN BY	GIVEN AT						
17-3-02	Clonidine	100 mg	g.m.		M.H.	G.S.	12.00 hrs.						
18/04/02	Decarbonate	100 mg	g.m.										
18/04/02	Decarbonate	100 mg	g.m.										

NAME OF PATIENT	AGE	DATE OF BIRTH	UNIT No.	CONSULTANT	WARD
Mr. H. G. G. G.	45	18/04/02	100	Dr. M. H.	Ward 10

MEDICINE RECORDING SHEET

KEY
 DRUG REFUSED
 PATIENT ABSENT

REGULAR PRESCRIPTIONS

AS REQUIRED

DEPT
IN SECTIONCOMMENTS ON
DISCREPANCIES

OTHER TIMES
Time Int

Code	Time
------	------

Code	Intls
------	-------

Int'l	Code
-------	------

Int'l	
pe	

COMMENTS ON
DISCREPANCIES

7/25/70			
K			

① Diagram

[illegible]

DMG only 18:00	DMG only 22:00
----------------	----------------

01/01/17

10

1000

100

1000

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• $\frac{1}{f}$

100

[illegible]

1000

10

10

[illegible]

--	--

[illegible]

1

2

(MR) 57

PRESCRIPTION SHEET (USE BLOCK LETTERS)

Sheet No.

START DATE	DISCONTINUED		REGULAR MEDICINES	DOSE	METHOD OF ADMINISTRATION	TIME OF ADMINISTRATION					PRESCRIBER'S SIGNATURE	
	Date	Signature				0800	1300	1800	2200	Other times		
A 2-4-02			Seclalene	50mg	0							
B												
C												
D												
E												
F												
G												
H												
I												
J												
K												
L												
M												
N												
O												
P												

START DATE	DISCONTINUED		AS REQUIRED MEDICINES	DOSE	METHOD OF ADMINISTRATION	INDICATION	MAXIMUM FREQUENCY	PRESCRIBER'S SIGNATURE
	Date	Signature						
R 2-4-02			Aspirin	7.5mg	0	Angina	Once	
S 2-4-02			Hydroperidol	5mg	0	Angina	Once	
T 2-4-02			Aspirin	1-2mg	0	Angina	Once	
U 2-4-02			Aspirin	5mg	0	Angina	Once	
V								
W								
X								
Y								
Z								

START DATE	DISCONTINUED		DEPOT INJECTIONS	DOSE	FREQUENCY	PRESCRIBER'S SIGNATURE	TICK IF PRESCRIBED ON THE FOLLOWING SHEET	LIST OF MEDICINES TO BE AVOIDED DUE TO PREVIOUS REACTION		REREFERRED DATE
	Date	Signature						✓	MEDICINE	
1 2-4-02			Seclalene	150mg						
2										
3										
4										

ONCE ONLY MEDICINES AND PREMEDICATION

DATE	MEDICINE	DOSE	METHOD OF ADMINISTRATION	TIME	PRESCRIBER'S SIGNATURE	GIVEN BY	GIVEN AT
2-4-02	Seclalene	50mg	0	11-30			
2-4-02	Seclalene	150mg	1m	11-30			

NAME OF PATIENT

Lean Gattler

AGE

DATE OF BIRTH

UNIT

CR 511

CONSULTANT

WARD

KEY
 (A) DRUG REFUSED
 (A) PATIENT ABSENT

MEDICINE RECORDING SHEET

[illegible]

NAME: Levi UNIT No: Grades 1-2 WARD: 2

INTERIM DISCHARGE AND PRESCRIPTION FORM

Queen Margaret Hospital

Whitefield Road, Dunfermline, Fife, KY12 0SU

DATE OF ADMISSION	27	/	10	/
DATE OF DISCHARGE		/		/
DATE CODED & ENTERED IN PAS		/		/
CODING DONE BY				
C.R.N.				

Dear Doctor

Your Patient

Address

(including Post Code)

Date of Birth

was admitted to hospital under the care of.....in ward.....
and is now being discharged/transferred to

Reason for Admission

Principal Diagnosis

Main Condition

Other Conditions
and/or complications -
to include external causes

1.									
2.									
3.									
4.									
5.									

Operations/
Procedures

1.									
2.									

A discharge letter will follow

Comments.....

Arrangements for review.....

The following medicines are recommended:-

MEDICINE FORM AND STRENGTH	DOSE	DIRECTIONS FOR ADMINISTRATION	RECOMMENDED DURATION OF TREATMENT	QUANTITY SUPPLIED
	150mg	2 tablets		28 x 7
	200mg	1 tablet		30 x 2
				36 x 1

Yours sincerely..... Date:.....

Name in Capitals

Designation Consultant ☒ Clinical Assistant ☐ Registrar ☐

Senior House Officer ☐ House Officer ☐

All Copies should be sent to Pharmacy Department and separated on return to Ward/Department.

Dispensed By:.....

Pharmacist:.....

Date:.....

1st White Copy - General Practitioner
2nd Pink Copy - Pharmacy
3rd Yellow Copy - Patient's Records

INTERIM DISCHARGE AND PRESCRIPTION FORM

Queen Margaret Hospital

Whitefield Road, Dunfermline, Fife, KY12 0SU

DATE OF ADMISSION	/	/	/
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DATE CODED & ENTERED IN PAS	/	/	/
CODING DONE BY			
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Your Patient

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and/or complications -
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2.									
3.									
4.									
5.									

Operations/
Procedures

1.									
2.									

A discharge letter will follow

Comments

Arrangements for review

The following medicines are recommended:-

MEDICINE FORM AND STRENGTH	DOSE	DIRECTIONS FOR ADMINISTRATION	RECOMMENDED DURATION OF TREATMENT	QUANTITY SUPPLIED
Aspirin	50mg	2 x 2 A.M.	7/7	1
Clopidogrel Tablets	200mg	2 M ^o 2 weeks		

Yours sincerely..... Date: 18-4-02

Name in Capitals

Designation Consultant ☐ Clinical Assistant ☐ Registrar ☐

Senior House Officer ☒ House Officer ☐

All Copies should be sent to Pharmacy Department and separated on return to Ward/Department.

Dispensed By:

Pharmacist:

Date:

1st White Copy - General Practitioner
2nd Pink Copy - Pharmacy
3rd Yellow Copy - Patient's Records



MULTISTIX* 10 SG REPORT

Name LEON GATTAN Date 17-3-02

Ward 2 Patient No. _____

TI

Please tick appropriate box for each test

LEUCOCYTES 1 to 2 minutes	NEG. ☐	TRACE ☐	SMALL +	MODERATE ++	LARGE +++		
NITRITE 60 seconds	NEG. ☐	POSITIVE (any degree of pink colour) ☐					
UROBILINOGEN 60 seconds	3 ☒	Normal 16 ☐	$\mu\text{mol/l}$ 33 ☐	55 ☐	131 ☐		
PROTEIN 60 seconds	NEG. ☒	TRACE g/L ☐	0.30 + ☐	1 ++ ☐	3 +++ ☐	≥ 20 ++++ ☐	
pH 60 seconds	5.0 ☐	6.0 ☐	6.5 ☒	7.0 ☐	7.5 ☐	8.0 ☐	8.5 ☐
BLOOD 60 seconds	NEG. ☒	NON HAEMOLYZED TRACE ☐	HAEMOLYZED TRACE ☐	SMALL + ☐	MODERATE ++ ☐	LARGE +++ ☐	
SPECIFIC GRAVITY 45 seconds	1.000 ☒	1.005 ☐	1.010 ☐	1.015 ☐	1.020 ☐	1.025 ☐	1.030 ☐
KETONES 4.5 mins	NEG. ☒	mmol/L TRACE 0.5 ☐	SMALL 1.5 ☐	MODERATE 4 ☐	8 ☐	LARGE 16 ☐	
BILIRUBIN 30 seconds	NEG. ☒	SMALL + ☐		MODERATE ++ ☐	LARGE +++ ☐		
GLUCOSE 30 seconds	NEG. ☒	mmol/L 5.5 TRACE ☐	14 + ☐	28 ++ ☐	55 +++ ☐	≥ 111 ++++ ☐	

*Trademark of Bayer Corporation, USA.

X600264 mpi

NURSING PROFILE

WARD 2 QUEEN MARGARET HOSPITAL

DATE OF ADMISSION: 17 MARCH 2002

CONSULTANT: Dr EDWARDS

PATIENTS NAME: LEON JAMES GRATTAN

KEYWORKER: ALISON GRAHAM
SCOTT ELVIN

ADDRESS: 85 SPITALFIELD ROAD
INVERKEITHING

NEXT OF KIN: Mrs LOANA GRATTAN

ADDRESS: 42 SPITALFIELD ROAD

TEL NO: 01383 416833

RELIGION: None SPECIFIC

TEL NO: 01383 420856
07762 602112

MARITAL STATUS: Single

WORK TEL NO:

D.O.B: 17.3.75 AGE: 27

RELATIONSHIP MOTHER

UNIT NO 5065370-

GP & ADDRESS Dr GARMONY
INVERKEITHING H.C.

OBSERVATIONS				STATUS				
DATE	GENERAL	TIMED/INT	SPECIAL	SECTION	START	TIME	LAPSE	TIME
17/3/02		15 min						
18/3/02	✓							

REASON FOR REFERRAL:

Emergency referral from GP. Leon had been brought to emergency doctor by the police. He had been experiencing paranoid ideation regarding a gas leak in his home and it was going to explode. Deterioration in mental state over the past seven days due to non compliance of medication.

SOCIAL CIRCUMSTANCES

Lives on own. Has two sisters Emma and Joanne who are very supportive. His parents live abroad. The carer from him and are also very supportive. Lived with girlfriend. He is social worker, have one son together split up → living alone now. Recently phoned ex-partner's boss at SW dept in Airdrie making accusations, charged by police for same.

PAST PSYCHIATRIC HISTORY:

known to services due to paranoid psychosis

Attends Afternoon detention once every two weeks?

Additional info - Sectioned Royal Ed? When, admitted to Monklands Hospital from Oct 2000 - Jan 2001 → Speaking in German accent → (Weight ↓ to 5 Stone)

MOOD LEVEL

Objectively low

Subjectively low

Rated mood on Scale of 1-10. (8)

Same agreed.

CLIENTS INSIGHT:

Limited insight happy to stay in the ward for safety

SUICIDAL IDEATION:

None voiced

MEMORY:

S/T States no problems

L/T-

ANXIETY SYMPTOMS:

Upon assessment very agitated, anxious quite hostile with responses fixed eye contact, restless

BEHAVIOURAL PROBLEMS:

Feels Very Angry re different issues in his life observed Leon's body language expressing fixed eye contact, becoming quite restless, stating he has been in many 'Scraps' involved in fights both Victim + Perpetrator

DRUG/ALCOHOL DEPENDENCE:

Denies any illicit drug or alcohol misuse

Smokes cigarettes

Additional information has used Cannabis from age of 13yrs, also LSD, Speed ^{claims} 30 minutes alcohol intake denies using any illicit drugs lately.

ESTABLISHING INTERACTIONS:

Limited rapport building regarding presentation.

THOUGHT DISORDER:

Paranoid belief that someone is trying to kill him by gas poisoning

Experiences both auditory and visual hallucinations

At time of assessment Leon responding to visual hallucinations stating someone threw a spark into room, sparks in day room, has to pace up and down to keep Viers from collapsing

COMMUNICATION:

Closed ^{body posture} head down no eye contact, voice low and soft. Interview suspended because Leon found it too difficult due to being tired

PAST MEDICAL HISTORY

EATING AND DRINKING

Dietary intake reduced regarding loss of appetite.

ELIMINATING

Claims no problems in this area.

SLEEPING PATTERN

Sleep pattern disturbed due to nightmares of people trying to kill him, tends to sleep in day.

PERSONAL CLEANSING /DRESSING

MOBILITY

No problems

ALLERGIES

None known

URINALYSIS

N.E.D

OBSERVATIONS:

T.

P.

R.

B.P.

ANY OTHER PHYSICAL PROBLEMS

Limited information.

SOCIAL WORKER: Ann Watson

C.P.N. Leslie Tweedie

HEALTH VISITOR

AGENCIES/SUPPORT ON ADMISSION

Hillview Day Hospital, not complying.

EMPLOYMENT/ BENEFITS

INSURANCE LINE

DATE ISSUED	NEXT DUE

HOBBIES AND INTERESTS

GENERAL DESCRIPTION

HEIGHT 6ft **WEIGHT** 135/4lb **BUILD** Slim. **EYES** **HAIR** Brown SHORT **SPECTACLES** NO **DENTURES** NO

DISTINGUISHING FEATURES

ANY OTHER IMPORTANT INFORMATION

Leon not complying with medication Prior to admission, also has had gas heard out on several occasions, thinks his food is also poisoned, ex Partner stopped Leon + mother seeing his son, due to allegations.

DATE	NURSING NOTES - Continuation
17/3/02 N/D 03³⁰ hrs	Leon was referred to the ward for assessment by the emergency GP. His mental state has deteriorated due to non-compliance of medication over the past week. Leon has become increasingly paranoid believing that his house is poisoned by carbon dioxide and it is about to "blow". Leon had turned on his water taps to stop the risk of fire from the gas leak. Gas board have found no evidence of a gas leak but have turned the gas off. Leon found it difficult to complete initial admission assessment due to tiredness mainly. The remainder of admission to be completed tomorrow. Leon's body language was closed with little or no eye contact during admission interview. He did not appear agitated and requested P.R.N. Lorazepam 2mg at 03-25hrs with good effect and quickly settled into bed and soon asleep. Plan of care Admit informally Place on 15 minutes observations initially to be reviewed tomorrow Medication as per drug book Assess mood and mental state
1230	P.H. Alden Leon remained in bed for the majority of the AM despite regular encouragement from staff to rise. Rose prior to lunch. Dr. Nersy yet to complete physical examination and will do so in early PM. Dr. Nersy also amended order to allow test dose of depot to be administered today. Depot of Zuclopentixol Decanoate 100mg yet to be given. D. H. Bage
1400hrs	Phone call received from Leon G.P. asking if we could contact her, to let her know where Leon is. Asked Leon permission to phone his mother, same granted by Leon. Mother contacted and made aware of Leon admission to ward. Stallard
1550hrs	Phone call received from Leon mother: MRS Gatten. She has visited Leon's house. Leon has flooded his spare room. He had called out friends at 2100hrs last night and they cut off his supply due to his fears of a leak. She described Leon's house as like a "tip" with dirty cutlery and crockery in every room. Stallard
4.2pm	From DR Nersy physical done, no problems noted. Refused test dose of depot medication to remain on 15 minute timed interventions at present. Blood to be done mon (FBC, U&E, thyroid function test and liver function test). Given P.R.N. Haloperidol 5mg @ 16.15 hours yet increased agitation with good effect. Remains quiet and settled in presentation, observations maintained.

DATE	LEON GENTON	NURSING NOTES - Continuation
17/14.3.02 N/D	2 15 minute intervals	At Home Leon noted to be laughing to unknown stimuli and appeared to be pacing the corridor quickly. Leon stated that he was experiencing difficulty getting off to sleep. He was offered and accepted Zopiclone 7.5mg at 23⁰⁰ hours with no effect. He continued to respond by laughing to unknown stimuli. Leon was offered and accepted Haloperidol 5mg and Lorazepam 2mg at 00.25 hours with good effect. He settled to sleep at 01⁰⁰ hours and remains asleep at time of report. Leon remains in general observation of 15 minute timed interventions P. Hadden
18.03.02	Feedback from Leslie Tweedie as she had met with Leon this am. Suggests that Leon panicked at home still to be reviewed by Dr Edwards continue with assessment on ward at moment. Leon still pacing a little this am. Late to rise out of bed. encouraged by staff to eat & drink to which same agreed.	P. Hadden
20.00	Leon this evening still appears agitated. has spent time in dayroom but reluctant to speak to others. visited by relatives this evening with them at time of visiting. Leon still occasionally pacing up and down ward.	Edwards
19.3.02 N/R	Reasonably settled in presentation. Retired around 11pm and has slept well.	L. A. Linnen
AM	ENCOURAGED ON MANY OCCASIONS TO RISE THIS AM. EVENTUALLY DOING SO AROUND 11AM. REMAINS DISTRACTED AND PREOCCUPIED AT TIMES. HOWEVER PLEASANT ON APPROACH - BLOODS TO BE TAKEN FOR FBC, U&Es, LFT & TFT. 1ST ATTEMPT UNSUCCESSFUL AND LEON TOO ANXIOUS FOR 2ND ATTEMPT AGREED TO THIS BEING DONE IN PM.	APL
PM	Spoke with Leon (I've been visiting alternate week to L. Tweedie) Leon seems to remember incident surrounding admission. Still v. angry with his ex-partner (Liz Gration) and not being able to see his son. Ann Watson.	Ann Watson
20.00	Leon spent some time between bed area and dayroom. Due to ward environment bloods were not done but Leon is agreeable for same to be done in AM. Requested to meet with medical staff re medication and when he may be discharged. Due to the time being	

DATE	LEON GENTON NURSING NOTES - Continuation
	after his regular Dr had left, Leon states he would wait until tomorrow for this meeting. D. King
19/3/02 OK	Appeared unsettled during the late evening; restless and pacing. When approached by staff, spoke of feeling anxious to get home and clean up the mess he'd made. Said that he had been feeling paranoid and had thrown a lot of water around. Requested to meet with staff to discuss bloods being taken and results. Expressed concern about his veins collapsing earlier today. Requested some reassurance although continued to appear agitated. Offered and accepted <i>pm</i> lorazepam 2mg at 2230 hrs with good effect. Has sleep well overnight. K.A. Turner
11.25 AM	Late to rise this morning. Does not appear to have attended to personal needs as yet. Continued to present as pre-occupied and distracted at times. Pleasant on approach from staff. Attending to personal needs at time of writing notes. S. Archer
P.M.	Leon approached staff requesting that his house be checked for a methane gas leak. S/P then met with Leon and reminded him that he had called the Transco emergency gas team out who had checked for gas leaks and had disconnected his supply. Leon says he is sure his house was filling with gas and heating up. Leon said these thoughts had been getting worse recently. Offered and accepted PRN Lorazepam 2mg at 1450 hrs with good effect. Settled in the evening and socialised with other patients. — K.A. Turner
20/3/02 NR	Leon appeared restless and unsettled overnight. Given <i>pm</i> lorazepam 2mg at 0025 hrs with little effect. Noted to be laughing and talking to himself whilst lying in bed. Offered and accepted <i>pm</i> haloperidol 5mg at 0340 hrs eventually settling to sleep at 0600 hrs. Leon has used garrison lozenges on two occasions for hiccups and indigestion brought on by a Chinese take-away. K.A. Turner
AM	Clinician meeting. - EXPRESSING NO PARANOID IDEATION - WANTS TO GET A JOB - BUT HAS BEEN SAYING THIS

DATE

Leon Gratton

NURSING NOTES - Continuation

TO HIS C.P.N. L. TWEDDIE FOR 6 MONTHS BUT
LACKS MOTIVATION TO DO ANYTHING ABOUT THIS
- CLINO TO BE ALIVE - NO SUICIDE IDEATION OR
PLANS

- TO HAVE TEST DOSE OF DOPOT TODAY
- TO ATTEND INTERVIEW WITHST ON WARD
- CLONAZEPINE REDUCED

TEST DOSE DOPOT GIVEN APPOINTMENT MADE
TO ATTEND INTERVIEW FOR INTERVIEW GROUP
NEXT MON AM.

Leon generally settled during afternoon, had a
bath and attended to personal needs assisting
staff to tidy bed area.

Approached staff this evening requesting information
as to when he would be discharged.
Advised medical staff would be consulted re
same, also would like pass out tomorrow
to buy birthday present for his mother.

P. Hunter

21

22.03.02

Spent the evening wandering between bed area and
dayroom, difficulty settling, offered and accepted
as required. Lorazepam 2mg at midnight, with some
effect, eventually settled and slept from 02.00.
Leon is returning was complaining of a tingling sensation
in his arms, which he says has been present for a
few days.

J. Bell

22.3.02

AM

Leon requesting pass this morning, advised
that medical staff have stipulated escorted
passes only, advised that this would be
assessed during afternoon if staff are able
to accompany him.

P. Hunter

22.3.02

PM

Leon has been settled this afternoon/
evening, sitting in between dayroom and
bed area. Visited Asda accompanied by
Mother to buy birthday present returning
appropriately.

Salt 615

23.3.02

MR Spent evening between dayroom and bed area, slept for long
periods overnight.

A. Ford

23.3.02

AM

Leon requesting to be prescribed 'E 45' cream for
dry skin. Plans to go on pass this afternoon
into town with his mother.

P. Hunter

(pm)

Approached staff appearing tense, anxious
and pre-occupied. Unable to elaborate
on thought process. Given 10mg cefazolin 1mg

23/3/02 at 17.15 hrs with a good effect. More settled
(pm) as evening progressed, although still appearing
pilo-occupied at times. Spent a short time
off the ward, in the company of his mother
at start of shift, returning appropriately. Slept
8.20pm Leon requested to know when he would be
discharged. Spoke with Leon, voiced paranoid
and suspicious thoughts regarding other being
nice to his face, but talking about him
when behind his back. Also spoke about
people being able to "dampen his thoughts"
and his ex-girl friend, being out to
harm him by getting back at him. Given
support and reassurance that staff would
not allow anything to happen to him. Satisfied

24.3.02 Appeared fairly settled during evening. Spent time between
lying on top of his bed & sitting in dayroom. Making no contact
with fellow clients. Slept well overnight. E. Black

24.3.02 Leon has had a settled morning. Spending time
in dayroom socialising with fellow patients and some
time resting on his bed. ————— Settle

24.3.02 weekend Summary

- Difficult to rise in mornings despite prompting
- Agitated at times, using Lorazepam 2mg with good effects
- Appears tolerant of test dose of depot, no side effects noted.
- Returning appropriately from day passes, excited at present
- Still has occasional paranoid and suspicious thoughts
- Mostly settled in mood, occasional anxiety / paranoia.
- keen to know plans for his discharge. ————— Settle

1719HRS Leon approached staff regarding feeling unsettled upon
further discussion Leon stated his thoughts were proving
difficult to cope with at times, presented quite agitated
and anxious PRN medication given at 1715HRS Haloperidol 5mg,
and lorazepam 1mg. ————— VJ

1800HRS Leon pacing quite a bit seemed quiet, but looked angry
in presentation made his way up to room area where
he slammed door, staff approached Leon regarding his expressed
anger to which requested to vent feelings, Leon informed
staff that mother blamed him again for losing contact
with grandson. also feels caught in middle of parents
arguments. Signs of poor family dynamics present,
contributing to Leon's mental state suggested Leon
remains in low stimulus area for time out to reduce
stress & anxiety. Some agreed. ————— VJ

DATE	LEON GRATTAN NURSING NOTES - Continuation
25.3.02	Settled during evening after receiving 10pm medication early. Spending short spells in dayroom. Retired early to bed. Has slept well overnight. E. Black.
25.3.02	Leon has been spending time at bed area and occasional time in dayroom with others - clearest in manner on approach. But says he is a bit disturbed by thoughts in his head. He is concerned about his flat and wishes to see doctors to discuss his discharge plans. Intends to see Dr. Newsey this afternoon if possible. Settled.
Ph	Dr. Edwards Meeting: - Discontinue Diazepam - to have pain from Thurs - Mon - Depot on Mon - discharge if pain goes well. - Reported O.G. crisis to Dr. Edwards - not recorded in nursing notes - prescribed Prochlorperazine 5mg PRN. Relieved
26.3.02	Restless & pacing a lot during evening. Requested & given P.H.W. Lorazepam 2mg. 21.40 hrs. This had no effect & Leon continued to be restless although pleasant in mood. Requested that I read a "horror story" which he is writing. I did so & content is quite "violent & gorey". Unable to settle for any length of time. Offered & accepted further P.H.W. Lorazepam 2mg. 22.45 hrs. Retired to bed & has slept soundly from 03.00 hrs. E. Black.
am	Appears more settled this morning. Conversing with staff when approached. Appears brighter and more relaxed in presentation. H. Mulligan
13.15pm	Leon's mother arrived on ward with clothes and cigarettes. When asked if she would like to see Leon she replied "Am I Hell" concerned over phone calls Leon has been making to her house and wishes staff if possible to monitor these. Mrs Grattan was clearly distressed stating "you ask him what he said to me" I will not have my life put at risk. Has requested to leave a message for L. Tweedie as she has tried to contact her on numerous occasions with no success. When message passed on to Leon he stated it is all about the grandchild and that it is his child and not his mother's. He then stated "I take it she is still not talking to me". H. Mulligan

DATE	Leon Gratton NURSING NOTES - Continuation
In	Discussed telephone calls and content of same with Dr. Edwards. Dr. Edwards has advised that Mrs Gratton should involve the police if feeling threatened by Leon. Leon is to be reviewed on Fri at 3pm by Dr. Edwards, depending upon outcome Leon may proceed on pass or arranged or for a short period. R/S
PM	Settled evening. NO PROBLEMS REPORTED. A/L
27/3/02	Spending time in dayroom during evening. Requested & given Zopiclone 7.5mg to help him sleep. Unable to settle, spending time between dayroom & bed area. Heard to be laughing loudly when lying on top of his bed. Unable to control same & unwilling to divulge why he was laughing. Offered & accepted PRN Lorazepam 2mg @ 00.25 hrs which had a gradual settling effect. Slept well from 01.00 hrs. B Black
AM	NIGHT DUTY REPORT GIVEN TO DR. NUNSEY. NOW PRESCRIBED SMALL DOSE OF HALOPERIDOL B.D AS LEON STATES HE HAS EXPERIENCED AN OCCASIONAL CRISIS PREVIOUSLY whilst in the ward. THIS HAS NOT BEEN WITNESSED BY ANY MEMBER OF STAFF. HALOPERIDOL TO BE INCREASED IF NO SIDE EFFECTS NOTED. LEON SETTLED THIS AM NO COMPLAINTS OFFERED ATTENDED HULLIAN INTRODUCTORY GROUP AT 11AM. RETURNED AT 12.15 STATING THIS HAD GONE WELL NO EVIDENCE OF SIDE EFFECTS THIS DUTY. A/L
4pm	Relaxation Session: Attended full session with prompting. Active group member Behaved consistently appropriate Expressed own needs successfully Can follow verbal instruction. Leon stated he enjoyed the same & friends
PM	Has attempted to contact his mother via the telephone on two occasions but was unsuccessful. Settled evening. NO signs of side effects of medication. R/S
28/3/02	Spent evening in the dayroom. Requested & given PRN Lorazepam 2mg at 22.05 hrs appeared more settled & has slept well overnight. R/S
AM	Reluctant to rise this morning. Approached myself requesting PRN for agitation and bumbling thought. Received Haloperidol 5mg at 11.35 hrs to good effect. A/L
1630	Offered relaxation group and declined. R/S
5pm	Dr. Edwards Team meeting. • Denied any involuntary hallucinations at present • Denied any current paranoid thoughts, however

DATE	NURSING NOTES - Continuation
28/3/02 6.45pm	Leon Grattan Stu believes he had a gas leak from to admission • Complaining of feeling anxious and nervous • Haloperidol medication increased to 3mg B.T.D • Dr. Edwards meeting with Leon tomorrow 29/3/02 • Depot medication 3 due Monday 1/4/02, same to be clarified with Dr. Edwards tomorrow • Escorted parole only at present. Same to be reviewed by Dr. Edwards tomorrow Slattery
8.15pm	Leon has presented as fairly settled this afternoon and evening. Has referred no complaints: Slattery
28/3/02 N/A	Requested and was given Lorazepam 1mg at 22⁴⁰ hours for agitation and refused to bed. He rose again at 01³⁰ hours complaining of agitation and feeling tense. Leon was offered and accepted a further Lorazepam 1mg at this time with good effect. P.H. 11/11
M	Fairly settled morning. Incomplainings. R.H. 11/11 Met with Dr. Edwards today and pass granted from today until Monday 1.4.02 when he will return for depot medication and further review from Dr. Edwards Working towards discharge next week. Proceeded on agreed pass in company of B. Watson who will return on Monday afternoon. J. Mulligan To be reviewed by nursing staff upon return from pass on Monday 1/4/02, if pass has gone well, may continue on pass until Thursday 4/4/02. Ann Watson who to visit Leon at home on Wednesday 3/4/02
19.20hrs	Dr. Edwards to review for discharge on Thursday 4/4/02. Telephone call received from Mrs. Grattan (mother), enquiring if Leon was in the ward, advised he was on pass. Stated she could get no answer from him via telephone today, but states they are having no contact at present, since last Saturday. Spoke of Leon having been out on pass in her company last Saturday 23/3/02 for two hours, and Leon had spoken about having no access to his son, and wanted his mother to try and get access

DATE	NURSING NOTES - Continuation Leon Gratton
	for him, which she is unable to do. Stated Leon spoke about having wished he had killed her last time. When asked to elaborate, stated that when Leon was 15/16 years old, he had tied a television aerial around her neck, attached to a television, and thrown the television out of the window & on another occasion had put his hands around her throat. Mrs Gratton felt at this time Leon was beginning to become unwell. Expressed concern that Leon has spoken of this past event now, and had also stated on 23/3/02, that the next time he will kill her. Stated that Leon had sent serious allegations via letter to ex-girlfriend at her work, and 5-6 weeks ago was charged by C.I.D. with breach of the peace. Stated that Leon does not leave his accommodation, as he is terrified, believing people will kill him, and are waiting for him. Mrs Gratton wishes an appointment with Dr Edwards and will telephone his Secretary on Tuesday 2/4/02 to arrange same.
	Above discussed with Dr. Nensley and Mrs Gratton advised to contact police, if feels threatened by Leon, or telephone the ward. A Graham
	Mrs Gratton stated she wishes to wait until her son apologises to her, regarding speaking about past incidents. A Graham
1/4/02 Am	Leon returned from pass, in the company of Shu Ann Watson. A Graham
pm	Depot given today and staff to consult with medical staff tomorrow re prescription of same. Appears relaxed and pleasant in presentation of Mulligan.
2/4/02	Generally settled around usual watchy T.V. requested and received request for Zopiclone 7.5mg and Lorazepam 1mg at 00.25, before going to bed. Settled quickly and appears to have slept well overnight. APL
Am	LEON ROSE WITHOUT PROMPTING FOR BREAKFAST. THEN RETURNED TO LIE ON TOP OF BED. 8am MOSS WITHHELD AS KARDOR NOT CLEARLY WRITTEN STAT DOSE SETRALINE GIVEN AT 11.30. LEON SETTLED IN PRESENTATION NO MANAGEMENT PROBLEMS. APL
cont.	DEPUT DISCUSSED WITH DR MINAR WHO STATES NO DECISION WILL BE MADE TILL CLINICAL MEETING ON Thursday. APL
pm	Remained settled in presentation during afternoon, approached staff requesting medication for increased agitation, no symptoms evident but given Lorazepam 1mg & 10 hours as per request. Settled & time

of report watching T.V. P. Hunter
 3-4-02 Leon appeared quite restless during
 N/R the earlier part of the shift.
 Requested and given prn lorazepam
 1mg and Zopiclone 7.5mg at
 22³⁰ hrs. Eventually settled at
 03⁰⁰ hrs after several attempts to
 settle in bed. Appears to have slept
 since. L.A. Rimmer

17:00 Leon initially settled till staff approached
 him re when he would be going on pass. He
 initially stated he didn't think he would
 cope being out on pass but was unable to
 elaborate on this. Given support and
 encouragement and left ward at 17:00 hrs.
 with his monitor. Due to return tomorrow.
 P.L.D. Lorazepam 1mg given at 14:20. APL

19:00 Leon failed to return from pass, telephoning the ward
 instead stating that he was too tired to attend.
 No review could be made for discharge therefore Dr Edwards
 has arranged to meet Leon at Inverkeithing Medical Centre
 to discuss options for care. Planned to meet Ambage
 at 9:30 am on 5-4-02.

5.4.02 Leon failed to attend outpatient appointment N/R by Edw Nolas.
 to be placed on pass over the weekend. to be
 reviewed by Dr Edwards on 8/4. He will discuss follow
 up N/R EPN, L. Tweedie or his return from annual
 leave. APL

8/4/02 Leon telephoned ward this morning and spoke with
 10:30 Keyworker. Stated he had not attended meeting
 with Dr Edwards on 5/4/02, as he had been unable
 to sleep the previous night, and had fallen asleep.
 Stated he had remained in his house over the
 weekend, but had called the police today, as states
 a mobile phone, and two remote controls had been
 stolen from his house. Stated police had visited this
 morning and taken relevant details. Appeared
 brittle in manner regarding same.
 Stated 'a guy is creeping in and out of the
 house', unsure of who this guy is, as he doesn't

DATE

LEON GERRAN

NURSING NOTES - Continuation

See him. States he has not slept well over the weekend. Asked Leon if he would return to the ward today, but he stated he would be unable to. Requesting Ann Watson slw collect him.

11:45hrs Dr. Edwards informed of above telephone call. Slw McGoggin + Anne Watson slw to visit Leon at home this afternoon at 2pm, to assess Leon within his home environment and if concerned regarding Leon's presentation Leon to return to the ward, to meet with Dr. Edwards this afternoon. If staying at home, Dr. Edwards will visit Leon at home on Wednesday 10/4/02 at 11:30am with CEN Hestley Tweedie.

Slw McGoggin to telephone Dr. Edwards following home visit to update.

11:50hrs Leon contacted and informed of home visit by Slw McGoggin + Anne Watson, social worker + agreeable to same. Requesting Slw McGoggin takes pass medication with him and Leon states he has not had ^{any} pass medication over the weekend. Abraham

16:00hrs FEEDBACK FROM HOME VISIT - LEON APPEARED FAIRLY WELL PRESENTED AND COPING TO A DEGREE WITH PASS. STILL EXPRESSING PARANOID IDEATION RE PEOPLE ENTERING HOUSE AT NIGHT WHICH IS AFFECTING SLEEP PATTERN HAS ALSO SHOWN DEGREE OF INSIGHT RE POSITIVE EFFECTS OF MEDICATION AND HAS AGREED TO INCREASE IN DEPOT MEDICATION. LEON STATES HE WILL RETURN ON WED WITH EITHER MOTHER OR ANN WATSON AS ESCORT. PASS MEDS LEFT WITH LEON INCLUDING OF X 4 LORAZEPAM 1mg P.R.N. AND ADVISED OF USE. NO ZOPICLONE LEFT DUE TO PREVIOUS SIDE EFFECT DR EDWARDS ADVISED AND HE IS HAPPY WITH SITUATION. HE WILL NOT BE IN WARD ON WED BUT REQUESTED DEPOT BE INCREASED TO CLOPIXOL 150mgs. DR SETH PRESCRIBED THIS IN KARDEX.

10-4-02
pm Leon returned to ward around 11:30 this morning. Appeared pleasant and appropriate in manner. Keyworker to meet with Leon this afternoon and discuss with him his mood/mental state while on Pass and Pass this onto Dr. Edwards. Leon is also due increased depot of 150mg Clopixol. ^{After} ~~Seth~~ Leon met with keyworker SN Elin today, after receiving depot medication. Remains paranoid requesting 7 day pass. Dr. Nershey has requested

Leon remain in the ward until review by Dr Edwards tomorrow, to which Leon is agreeable. Metive

Requesting lorazepam 1mg at 18.00 per agitation. Same given Metive

Leon requested to meet Leon expressing concerns that lorazepam was giving him "rumbles" similar to those he experienced when using illicit substances. Leon requesting if there was any other form of medication that he could use for agitation. Advised that he could discuss this with Dr Edwards tomorrow at his meeting. Requesting passes tomorrow - reminded to discuss same tomorrow. Advised Leon unwilling to socialise in sitting room as it was too noisy and other patients are bad visitors. Shepherd

11/4/02 Settled evening. Spent short time in day room because of incident happening in corridor area of the ward. He was later heard to be laughing loudly in the bathroom. Asked if he could sit with staff for a time in the corridor. Ordered a carry out pizza for his supper prior to retiring to bed. Has slept well overnight. E. Black

(Am) Leon mother requested to speak with staff. She said that Leon house is still in a mess, she will clean same this week. Mrs Grattan requested an update on Leon progress. Same given - Leon mother will not be into Leon next week, as she is going on holiday.

11/4/02 Leon bathed this morning and spent the remainder of the morning in the day room. Slaters
Slightly agitated whilst talking with his mother. However settled and appropriate otherwise. ST/N Jandiland Shepherd

PM

Feedback from Dr Edwards Meeting

- Still Expressing delusional beliefs
- Accepted increase in increased medication/alap
- Lesley Tweedie completing referral to CCT
- Leon experiencing Anxiety Symptoms
- Keywork to if possible to complete referral to OT re-graded exposure programme - as Paula or is meeting with Leon on Friday 12/4 to start programme.
- Pass Planned for Friday 12/4 over weekend telephoning Monday 15/4 for review of condition

DATE	Leon Glatton	NURSING NOTES - Continuation
Continued	Keep bed for moment	VAT
11/02	Leon Same in presentation no change	VAT
12.4.02	Leon asked to bed at 2200 hours and appears to have slept well overnight rising at 06 ¹⁵ hours	P.H. Hadden
1205	Leon due to go on pass as planned at 1400HRS pass meds done, on trolley ready. Settled on ward. no change in presentation	VAT
12/4/02	OT initial interview to discuss arrangements for a home visit on Wed. 17th April. Leon is happy to co-operate in graded exposure work with the OT for using public transport.	P. Cura OT
(pm)	proceeded on pass home over weekend, due to contact ward on Monday 15/4/02, to inform staff, if pass has went well. pass medication supplied until 15/4/02 only.	Stallions
13/4/02	Referral to OT Paula Cura, regarding graded exposure work as documented on 12.4.02 by OT Paula Cura, completed a Graham	
16/4/02	Highlighted Leon's non-return from pass to Dr Nersey. Also no prescription of further depot medication. Dr Nersey is meeting CPN H. Tweedie on Thurs AM, therefore no plan of care or depot given until then.	T. Mettew
13.35	Leon contacted ward requesting confirmation of O.T visit planned for tomorrow. Advised Paula not available today but will phone him in the morning to confirm. Leon was reminded he should have returned to ward on 15th - stated he plans to return tomorrow with O.T and confirmed pass is going well.	P. Hadden
17/4/02	If Leon does not return, Lesley Tweedie to be informed before 2pm & she will visit him. Awaiting clarification from OT Paula if she is visiting him today.	T. Mettew
10.00	Leon returned to ward this am, laughing inappropriately with no obvious stimuli in day room requesting depot medication, but explained this has not been with up to him can not give.	VAT
12.30	Seen by Dr Nersey. Depot now changed to 200mg fortnightly. AS LEON IS COMPLAINING OF OVERSEDATION ONLY 1mg Lorazepam PRN TO BE ISSUED WITH PASS MEDS. Depot to be given today and overnight pass meds supplied from trolley.	APL
1400	Prior to staff being available to administer depot and supply medication, Leon was noted to have left the ward. As yet he has not returned therefore arrangements have been made for CPN Lesley Tweedie to visit.	

Leon at home tomorrow and administer depot. Staff to confirm the arrangement with Lesley later today. ~~to~~ ^{leave} on
At end of shift Leon has not yet returned to ward. ~~Off~~ ^{Off} George
Lesley Tweedie to be contacted and will meet up with Leon tomorrow. ^{Off} George

18/4/02 LESLEY/TWEEDIE C.P.N. COLLECTED NEWLY WRITTEN KARDEX FOR DEPOT WHICH SHE WILL ADMINISTER THIS AT HOME. CARE WILL BE REVIEWED AT CLINICAL MEETING IN P.M. WHEN LEON WILL PROBABLY BE DISCHARGED. ? LEON HAS ANY MEDICATIONS AT HOME. ^{Off} George

DR Edwards Team meeting

- Returned to ward for clinical meeting
- Reports mental state improved with better concentration
- C.C.T.T. referral made by L. Tweedie, for follow up
- To receive depot. Start of next week: 200mg. Clozapine 2/52; Lesley Tweedie unable to do same, on holiday. Staff to contact C.C.T.T. to see, if they can give Leon his depot next week.
- Discharge today; follow up C.C.T.T. Hillview out patients and D.T.
- Discharge medication ordered; Leon given enough medication until beginning of week. Who even does ~~to~~ Leon depot; to collect his discharge medication and take same out to him.
- Gao back on; gao board found leak.
- Mother is currently on Holiday in Spain.

Discharged as planned above. Referral sent to ^{Stathern} John Gillen to administer depot and deliver discharge medication. - A. Dea

fife healthcare NHS TRUST
MENTAL HEALTH SERVICE

GENERAL Observation Care Plan

Patient Name LEON GRAYAN DOB 27-3-75 Unit No.

Ward Two Responsible Consultant Dr EDWARDS

Physical Description

Height	<u>6ft</u>	Hair	<u>SHORT BROWN</u>
Weight	<u>135+ 4</u>	Build	<u>Slim</u>
Eye Colour		Dist. Features	

GENERAL Observation Approach

The patient must be accounted for at least at meal times, medication times and at the change of shifts. Any other individual interactions, instructions or constraints will be documented in the care plan and reviewed at intervals determined by the primary nurse. Time out only after consultation between the nurse in charge and primary nurse.

Reason for Approach / Risks Identified

Deterioration in mental condition causing increased paranoia which may cause Leon to be a danger to himself or anyone else.

Specific Interactions / Instructions / Constraints

15 minute timed interventions
15 minute timed interventions discontinued 18-3-02
NO SPECIFIC timed interventions SB

Prescribing Nurse Signature Patricia E. Hobbins Grade Staff Nurse Date 17/3/02

General Observation Upgraded to: **SPECIAL / CONSTANT** (delete as required)

Nursing Signature Date

Medical Signature Date

(Note: A medical signature is not essential when upgrading status)

Review Notes Overle

Patient Name: Leon James GATTINDate of Birth 17-03-75

Unit Number.....

Care Plan Number 1Date care plan initiated 18/3/03**Problem Statement:**

Leon is Presenting with Paranoid beliefs that People are trying to kill him by gas poisoning resulting in restless agitated behaviour, disturbed sleep pattern and loss of appetite

Patient's perception of identified problem:

Leon has little insight into his mental state at present.

Goal (action which patient hopes to achieve regarding the specific problem identified):

It is hoped that Leon will manage agitated/restless behaviour to a level that is acceptable, restore an appropriate sleeping pattern and achieve a considerable improvement in appetite and decrease in hallucinations to a manageable level.

Date	Interventions	Signature
18-3-01	• Leon is admitted informally and is not desirable if wishing to leave.	Estlin
18-3-01	Administer medications as per order and monitor the effects and side effects.	Estlin
18-3-01	Encourage Leon to take reasonable dietary intake.	Estlin
18-3-01	Give opportunity for Leon to vent his feelings regarding paranoid beliefs and assist in building a therapeutic relationship.	Estlin
18-3-01	Allow Leon to discuss his nightmares give reassurance and provide suitable environment for sleep.	Estlin
18-3-01	Encourage Leon to use relaxation sessions as an aid to reduce anxiety and relief from voices.	Estlin
18-3-01	Leon is maintained on general observations with 15 minute timed observations - Discontinued 18-3-02	Estlin
6/4/03	Was maintained on general observations with no specific timed interventions.	AGraham
6/4/03	Passes as agreed by medical staff.	AGraham

Care Plan Review Date

Care Plan

Patient Name: Leon Gaffar.....

Care Plan Number.....

Date care plan initiated.....

Care Plan Discontinued on(Date)

Goal Achieved	Yes / No	(Delete as appropriate)
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Care Plan Rewritten on(Date)

NAME :- Leon Gration

TEL NO -

DISCHARGE PLAN

DISCHARGE PREPARATIONS.

1. Planned date of discharge 18-4-02
2. Who initiated the discharge plan Dr Edwards / Leon
3. Has there been a period of passes prior to discharge yes
4. Are discharge plans clear between the patient, keyworker, and medical staff.
Relatives to be informed if directly involved. ☒
5. Patient reaction to discharge plans. Keen
6. Prior to discharge referrals to appropriate supports are to be submitted.
Hillview ☒
C.P.N ☒
Social work ☒
Key worker/O.T input ☒
Others(specify) _____
7. Discharge medication ordered. ☒
8. Patient aware of date for out-patient /depot clinic appointment. ☒
9. Patients valuables are returned. ☒
10. Patient issued supply of discharge medication. ☒
11. Patients GP to be informed of discharge.
12. Patient issued a discharge line for D.S.S & discharge letter for GP. ☒
13. Documentation to be completed -: nursing notes/admission/discharge book
bed state folder ☒
14. Ensure case notes & profile are sent to the appropriate place
15. Remove patients name from keyworker board. ☒



MULTISTIX* 10 SG REPORT

Name Leon Grattan Date 09.12.03

Ward 2 Patient No. _____

TESTS Please tick appropriate box for each test

LEUCOCYTES 1 to 2 minutes	NEG.	TRACE	SMALL	MODERATE	LARGE
NITRITE 60 seconds	NEG.				POSITIVE (any degree of pink colour)
UROBILINOGEN 60 seconds	3	16	33	66	131
PROTEIN 60 seconds	NEG.	TRACE	0.30	1	3
pH 60 seconds	6.0	6.0	6.5	7.0	7.5
BLOOD 60 seconds	NEG.	NON HAEMOLYZED	HAEMOLYZED	SMALL	MODERATE
SPECIFIC GRAVITY 45 seconds	1.000	1.005	1.010	1.015	1.020
KETONE 40 seconds	NEG.	TRACE	SMALL	MODERATE	LARGE
BILIRUBIN 30 seconds	NEG.		SMALL	MODERATE	LARGE
GLUCOSE 30 seconds	NEG.	TRACE	14	28	56

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FIFE AREA LABORATORY TELEPHONE MESSAGE PAD

Name Leon Grattan D.O.B. 17/3/75
Date 27/11/03 Time 14:35

ELECTROLYTES	Sodium	142	mmol/L
	Potassium	4.2	mmol/L
	Bicarbonate	27	mmol/L
	Urea	3.8	mmol/L
	Creatinine	98	μmol/L
GLUCOSE	Glucose		mmol/L
MISCELLANEOUS	Amylase		u/L
	Magnesium		mmol/L
CARDIAC	AST		u/L
	CK		u/L
	HBD		u/L
ARTERIAL BLOOD GASES	pH		
	Base Excess		mmol/L
	Std Bicarbonate		mmol/L
	PCO2		kPa
	PO2		kPa
DRUGS	Paracetamol	0.07	μmol/L
	Salicylate	0.07	mmol/L
LIVER	Total Bilirubin		μmol/L
	Albumin		g/L
	Total Protein		g/L
	Alk Phosphatase		u/L
	GGT		u/L
BONE	Calcium		mmol/L
	Corrected Calcium		mmol/L
	Phosphorus		mmol/L
CEREBROSPINAL FLUID	Glucose		mmol/L
	Protein		mg/L

HAEMATATOLOGY	
WBC	10.1 x10 ⁹ /L
Hb	16.5 g/dL
MCV	fL
PLATELETS	266 x10 ⁹ /L
P. VISCOSITY	cp
NEUT	%
LYMPH	%
MONO	%
EOS	%
BASO	%
FILM COMMENT	
COAGULATION	
OSPT	secs
APTT	secs
T/TIME	secs
FIBRINOGEN	g/L
INR	
MISCELLANEOUS:	
PHONE CALL TAKEN BY:-	

Fife Primary Care NHS Trust – Mental Health Directorate
ADMISSION INFORMATION SHEET [A1-Dementia]



Patients Name Leon Gration Unit No F5153833 Named Nurse _____
WARD TWO Hospital QMH Date/Time 27-11-03 15:40

1 Personal Information.

Known as <u>LEON</u>	Date of Birth <u>17-3-75</u>	Maiden Name _____
Home Address <u>85 SPITALFIELD RD INVERKEITHING KY11 1DZ</u>	Current Address _____	Place of Birth <u>GLASGOW</u>
Present/Past Occupation <u>Labourer Glass factory</u>	Religion <u>Atheist</u>	Ethnic Origin <u>WHITE</u>
Observation Status <u>General</u>	Allergies <u>Horse Hair</u>	Is English first language Yes ☒ No ☐ Preferred Language _____ Is an Interpreter wanted ☐ Is an Interpreter present ☐ Relationship to client (if any) _____

2 Main Carer (Other Relatives – Carer Information)

Full Name <u>LOENA GRATION</u>	Known as _____	Relationship to patient <u>MOTHER</u>
Home address <u>41 SPITALFIELD RD INVERKEITHING</u>	Telephone No <u>01383 420856</u>	Does this person live alone Yes ☐ No ☐ Transport/problems in visiting _____
Detail of person to be contacted if patient is sick, dying or in any emergency Name _____	Relationship Address _____	Order of Contact: _____ Cut off time _____ _____ Cut off time _____ _____ Cut off time _____ _____ Cut off time _____
Other Family support Name _____	Relationship Address _____	Other Relevant Information _____

3 Socio-economic details

Legal status on admission Informal ☒ Guardianship ☐ Care Programme Approach ☐ Mental Health Act ☐ Community Care Order ☐ Other – (Specify) _____ Power of Attorney – Name _____ Guardianship/Curator – Name _____ Valuables/Property Book _____ Disclaimer form signed by <u>Leon Gration</u>	Mental Health (Scotland) Act – Section _____ Date commenced _____ Welfare Power of Attorney _____ benefits received (Specify) _____ Pension Book/s etc _____ Keys _____
Other issues requiring to be managed; _____	

ADMISSION INFORMATION SHEET [A1-Dementia]

Patients Name Lion Caird Unit/CHI No P5153833

4 Diagnosis

Psychiatric Diagnoses <u>? Schizophrenia</u>	Physical diagnosis
Psychiatric symptoms currently receiving medical/psychological treatment <u>DEPRESSIVE SYMPTOMS</u>	Medication received/Current Medication <u>MELATONIN long note</u> <u>Dispo</u>
Relevant Medical Conditions	

5 Community service involvement

[includes name, addresses & telephone number.]

Name	Address	Tel No's
Consultant Psychiatrist <u>Dr Cavanagh</u>	<u>10 Ward 2</u>	
General Practitioner <u>Dr GARMAN</u>	<u>5 FRIAR COURT, INVERKEITHING</u>	<u>413234</u>
Social Worker		
Community Psychiatric Nurse <u>John Hamilton</u>	<u>C.O.T. Harrow House, Priory Lane</u>	<u>432725</u>
District Nurse		
Care Programme Approach Co-ordinator <u>John Hamilton</u>		
Home Care Manager		
Other involvement <u>DAVID MURRAY</u>	<u>SUPPORTING PEOPLE - PERMUTAT</u>	

6 Special Needs/requirements

(including: special dietary requirements, special language/communication needs, religious/cultural requirements especially when sick, dying or deceased) and mobility

no problems

7 Safety/risk problems/potential problems

Current risk and safety factors (such as potential suicide risk; persistent walking/falling/personal road safety risk; proneness to choking/fits; risky behaviour, such as leaving on unit gas appliances) Risk of Aggression

Risk of aggression towards mother

Fife Primary Care NHS Trust – Mental Health Directorate
ADMISSION ASSESSMENT / HISTORY TAKING [A1-Dementia]



Patients Name Lion Gration

Unit/CHI No F.515.3833

8 Main Carer/relative's perception & understanding of illness

(including: understanding of diagnosis and likely prognosis, reasons for current admission and awareness of likely future placement)

Finding Lion to be Paranoid, Accusatory and Distant towards me.

9 Nursing observation of patient's mental state

(including: observations of initial behaviour and mental state, reaction to hospitalization, current level of orientation and potential problems in adaptation)

Voicing Paranoid ideation, thoughts re: ex-partner/mother. Responding to ~~the~~ voices he is hearing at present.

10 Nursing observation of patient physical state

Temperature 35.6°

Pulse

Blood Pressure

100/62

Urinalysis TRACE PROTEIN (09.12.03)

Small BILIRUBIN Skin State

Glasses

Hearing Aid N

Dentures

Dentures Marked:

Yes ☐

No ☐

11 Physical appearance & recent photographs for records (Recent Photograph)

General Appearance Tidy

Distinguishing features Tattoo X6 Back/Neck

Height 6ft 2"

Weight 145T

Build

medium

Eye Colour

Blue

Hair colour Brown

Shoe Size

Posture

Correct

12 Physical problems experienced at home/previous care setting

(including: level of mobility and walking skills, postural problems, weight loss, nutritional problems, continence problems, skin care problems and level of physical frailty)

Pain in ribs? Cause.

13 Self Care problems experienced at home/previous care setting

(including: level of self-care problems, skills and abilities in washing, dressing, feeding, bathing and toileting)

Less motivation to attend to same.

14 Communication problems experienced at home/previous care setting

(including: level of verbal and non verbal communication skills/impairment, and problems, such as swearing, repetitive questioning, or verbal aggression)

Swearing at mother - normal behaviour.

15 Confusion problems experienced at home/previous care setting

(including level of memory impairment, level of disorientation in time place and person, confused behaviour)

Paranoid Delusions.

Fife Primary Care NHS Trust – Mental Health Directorate
ADMISSION ASSESSMENT / HISTORY TAKING [A1-Dementia]

Patients Name Leon Crockett Unit No F553833

16 Behaviour experienced (problems) at home/previous care setting

(including: persistent walking indoors and/or outdoors, repetitive behaviour, resistance to being cared for, episodes of verbal and/or physical aggression)

Verbal/Physical aggression towards mother.

17 Other experienced at home/previous care setting

(as expressed by main carer/other relatives or staff)

18 Emotional problems experienced at home/previous care setting

Expressed emotional problems experienced whilst at home regarding past member of staff.

19 Other Relevant Admission History Information (including reasons for current admission)

20 Past Psychiatric admission details /Respite dates / Changes in admission history

GENERAL Observation Care Plan

Patients Name: LEON CROFTONDOB: 17-9-75

Unit/CHI No.

Ward: TWOResponsible Consultant: DR CAVANAGH

Physical Description

Height	<u>6'</u>	Hair	<u>Brown</u>
Weight		Build	<u>MEDIUM</u>
Eye Colour		Distinctive Features	

General Observation Approach

The patient must be accounted for at least at meal times, medication times and at the change of shifts. Any other individual interactions, instructions will be documented in the care plan and reviewed at intervals determined by the primary nurse/key worker. Time out only after consultation between the nurse in charge and primary nurse

Reason for Approach/Risks Identified

--

Special Interactions/Instructions/Constraints

<u>NO TIMES INTERVENTIONS</u>

Prescribing Nurse Signature: [Signature] Grade: E Date: 27-11-03

Review

Date	Outcome	Date	Outcome

General Observation Upgraded to: SPECIAL/CONSTANT (delete as required)

Nursing Signature: Date:

Medical Signature Date

(Note: A Medical Signature is not essential when upgrading status)

Ward /Dept 2

Name: <u>Leon Gratton</u>		Care Plan Number 1	
C.H.I. Number	Unit Number <u>F515 3833</u>	Date Commenced <u>27/11/03</u>	
Consultant/G.P. <u>Dr. Cavanagh</u>	Prescribed By Named Nurse: <u>Linda Payne</u>		Date Resolved
Description of Need: Client is experiencing an altered mental state requiring admission to hospital for admission			
Objective/Expected Outcome To complete a nursing assessment of the client's mental state from admission, thus providing a basis for the formulation of the care particular to the client's need			
Actual Outcome			
Evaluation/Review No	Date Due	Evaluation/Review No	Date Due
1		6	
2		7	
3		8	
4		9	
5		10	

BMI

Physical condition

Rollator

Handling constraints:

Behaviour which may affect safe handling:

Action plan discussed with client/carer yes/no

Date: 14/12/03

Signature: Linda Paine Designation: D.N.

Designation:

Patients/Client Name

Leon Carron

Unit Number / CHI

F5153833

Date of Birth

17-3-75

Named Nurse/Key Worker

Arison, LINDA, PREVIC

Date: Time:	Multi Disciplinary Record of Important Information not held in Evaluation/Review/Variation Records etc	Signature
27-11-03 18 ²⁵	Informal admission today of this 28 year old male well known to the psychiatric services. Referred to ward by C.O.T. Following overdose of Melatonin medication last night. Experiencing lowering of mood over past few weeks. Unable to sleep at present, due to "voices" he hears, at night. Last night felt unable to cope with voices and impulsively took overdose. Describes people having access to his thoughts and also receiving messages from the T.V. <u>Russ</u> - Admit informally. • Placed on general observation • Monitor mood & mental state • Assess for detainability if wishing to leave. Leon has spent much of the time since arrival on the ward pacing between day room and back area. No interaction with fellow patients noted other than when directly approached. Pleasant or interactive with staff. Noted to be "talking" to himself at times with no obvious stimulus. Visited by mother in the evening who describes several months worsening of symptoms. Mother also describes no sleep over past two nights.	
28/11/03 12 ³⁰	(NR) Up several times throughout the night. appears suspicious and guarded. Made conversation with staff member. Late to rise this morning, requires to attend to his personal hygiene. Sullen in presentation. Weekend Pass Plan From Dr Belandage may have may have escorted passes in hospital with staff, mother and WfCOT. Dr Ho to confirm Depot medication this pm	H Mitchell
20-15	Leon has spent time constantly pacing corridor no interaction noted with other clients. Visited by his family during evening. Requested to be escorted to juice machine, appropriate in manner during this time.	P Hunter
29/11/03 0700	Generally settled in presentation & pleasant in manner on approach. spent most of the night between dayroom & back area, has not slept at all.	CRICK

Patients/Client Name

Unit/CHI Number:

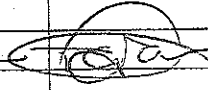
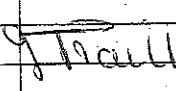
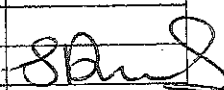
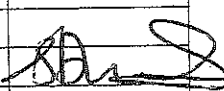
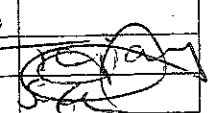
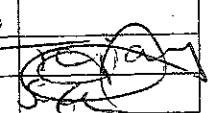
LEON GRATTON

Date: Time:	Record of Important Information not held in Evaluation/Review/Variation etc	Signature
29.11.03 12.00	Leon experiencing increased agitation this morning. Discussed his presentation with Dr Sam and Leon was prescribed Haloperidol and Lorazepam on P.R.N basis. Leon was given Haloperidol 5mg @ 09.30 hours with good effect. Has remained settled throughout morning.	P. Hunter
19.30	Leon slept until just prior to dinner, he was settled & stated he felt better due to the haloperidol. His family visited in the evening, where he was settled throughout.	P. Hunter
30.11.03	Leon was requested & given 2mg Lorazepam & 5mg Haloperidol. He felt the benefit of this given his night sedation at 11pm. He has slept well overnight.	P. Hunter
3.11.03	Leon stated to me this morning, attended to personal needs and has spent time in dayroom, but little social interaction noted although appears quite settled in presentation.	P. Hunter
20.30	Leon became agitated and requested as required Haloperidol 5mg @ his with good effect for a short period. Leon began to pace the corridor and again requested as required medication. Was offered and accepted Lorazepam 2mg @ his with some effect. Leon requested that staff speak to his mother, Mrs Grattan spoke of her increased fear of Leon as he has become increasingly hostile towards her and has been phoning her work and has been talking about her to her colleagues. He also threatened to charge her with the police as he accused her of threatening him. His mother is now frightened to have Leon visit her at home if she is on her own. Leon admitted that he was being distressed by voices but was reluctant to discuss this in the company of his mother. Leon's mother has requested to be given a copy of the letter Dr Cavanagh received refusing Leon psychology input as she wishes to take the matter further. SIN Gray and SIN Dimmond met with Leon to discuss further the distress of the voices. He advised that there are several	P. Hunter

Patients/Client Name

Leon Gratton

Unit/CHI Number:

Date: Time:	Multi Disciplinary Record of Important Information not held in Evaluation/Review/Variation Records etc	Signature
30/11/03 Cont'd	none of which he recognised except for one which was that of a student nurse he had developed feelings for on his 1st admission to the ward. He spoke of some hating feelings but stated he would not act on these as he then the police would become involved. He spoke of the other voices, one he described as a girl screaming, others he stated were saying they were paedophile. He stated that he calls his mum as a diversion at times and that the voices do increase at night times. Reassurance and support given.	
1.12.03	Leon again stating concerned in voices. Accepted 2mg Lorazepam + 5mg Haloperidol at 23.00hrs, he felt this was effective and requested his night sedation at 23.00hrs. Again Leon settled & slept well.	
11.55	Dr Cavanagh's meeting:- • Monitor mood and mental state • Escorted passes in hospital grounds with staff members only	
12.25	Settled morning. Woken from bed to meet with Dr Cavanagh, appropriate throughout. Spent morning socialising in dayroom with fellow patients.	
20.50	Leon requested and received as required Haloperidol 5mg @ 17.15hrs with some effect as he was becoming increasingly agitated as a result of distressing thoughts. He later requested and received as required Lorazepam 2mg @ 18.15hrs with good effect. Leon's mum visited this evening, the discussion became quite loud with Leon becoming increasingly belligerent and aggressive in manner, however he eventually settled. Spent time in company of staff and was pleasant and polite. Staff to contact WF cot in RM to arrange for support worker to visit Leon for some escorted time off the ward within hospital if possible.	
1.12.03	Depot given today Clopixol 250 to D Side	

Patients/Client Name

LEON GRATTON

Unit/CHI Number:

Date: Time:	Multi Disciplinary Record of Important Information not held in Evaluation/Review/Variation Records etc	Signature
01 02.12.03	Quiet in presentation requested and given as required Lorazepam 2mg and Haloperidol 5mg at 21.55, retires and has slept well overnight.	
10.15 19.12	Quick and alert - appearing slightly perturbed lying in bed. Leon was complaining of dry irritating skin between his fingers. Dr Johnston has now prescribed Diprosone on a p.r.n basis, some given 21.15 hrs. Leon's mother visited this evening and appeared to go well, both boys appeared to enjoy some and appeared more relaxed at times. Leon reports that the so far required moderate has been beneficial.	J.R.
3/12/03 06.30	Quiet in presentation, requested and given as required HALOPERIDOL 5mg's at 21.55hrs retired to bed although unable to settle requesting LORAZEPAM, some had been discontinued daily doctor contacted and prescribed STIM dose ZOPICLONE 7.5mg's at 23.00hrs. with no effect. Again requested and given P.R.N 5mg's HALOPERIDOL at 02.40 hrs. Leon has not slept at all overnight. Aired Team Meeting.	T.R.
	• Continue to display ? paranoia re mother • Evidence of irritability towards mother • Using P.R.N Haloperidol as per order with effect • Prescribed Temazepam route to aid sleep • Continue passes within the hospital • Continue present care.	
20.45	Visiting for AM, displaying no change in presentation. Visited by his mother this evening and although Leon appeared tense at times in her company, no overt paranoia evident on this occasion. did show some irritability on occasions towards mother. Settled otherwise around ward. Requested and given Dermabase cream at 20.50 for skin irritation on his fingers.	AM Gough
9pm	Requested and given as required Haloperidol 5mg's for distressing auditory hallucination, as per order, with effect.	S.L. Anthony

Patients/Client Name

Unit/CHI Number:

LEON GRATTON.

Date: Time:	Multi Disciplinary Record of Important Information not held in Evaluation/Review/Variation Records etc	Signature
4/12/03 07:00	No change in presentation, quiet and generally settled during the evening. Received TEMAZEPAM 10mg at 22:00hrs. Late to settle, eventually slept well from 01:00hrs.	Elleick
12:00	Spent majority of morning in bed, attending day room for dietary and medical purposes only. Pleasant in manner, no further problems to report.	Rhogan
9:10	No change in presentation.	(Signature)
4/12/03	Spent evening in the sitting room watching TV, retired to bed around 00:30 and has slept soundly overnight.	Elleick
	Related Entry 4.12.03: Leon expressed his concern of having been prescribed Temazepam and although he agrees this is effective he is concerned re usage of same as he became extremely addicted to same in the past. He spoke of Zopiclone being slightly effective, on further discussion it was noted that Leon had only ever been prescribed 7.5mg agreed to speak with medical staff in the morning.	Elleick
12:35	From Dr's meeting this morning, Dr Ho now prescribed Zopiclone ^{7.5mg} 15mg nocte. Melatonin remains prescribed until Dr Cavanagh attends Ward this afternoon as Dr Ho wishes to discuss this further as she is unsure how Dr Cavanagh wishes to proceed. Leon has spent a fairly settled morning.	Elleick
	<u>Weekend Pass Plan</u> Unescorted within / escorted out	
12:35	Contracted team to establish if it would be possible for escorted pass over today or weekend. Support workers unable to assist today but will leave message for other staff members to establish if they can assist.	Elleick
5/12/03	Appearing pleasant and settled in presentation this P.M. visited by his Mother and Son, observed to be appearing tense on occasion during visit. No complaints expressed.	Elleick
05/12/03	Settled evening, spent time socialising with staff and fellow clients. Refused prescribed Melatonin at 10pm. Encouraged to retire and has slept well.	Elleick
06/12/03	Leon was earlier to rise, was visited by his son and mother and spent time off the ward in their company. Colin Welsh from WF 40T	Elleick

Patients/Client Name

Unit/CHI Number:

Leon Gratton

Date: Time:	Multi Disciplinary Record of Important Information not held in Evaluation/Review/Variation Records etc	Signature
	Will collect Leon tomorrow @ 10:30am and will escort him home to collect some belongings Leon and/or same.	
19.15	Leon appeared to be relatively quiet but conversed appropriately with staff & patients like. Visited by his mother in the evening, and appeared to enjoy some.	T. Gray
19.12.03 NR	Leon has slept very little overnight despite receiving Zopiclone 15mg at 10pm. Has spent the night reading or writing his book. Remains settled in presentation.	LA Rimmer
6.12.03	Colin with COT took Leon home for clothing. No problems, Leon picked up clothes/COT and came back to ward without complaint.	
12.30pm	Rose early, presenting overly bright and overly far from involved with fellow clients behaviour/presentation. Escorted home by Colin with as documented above. presenting SELS	St. Andrew
19.55	Spoke with Leon today Leon expressed he was bored in the ward and wished to know when he will be discharged. It was put to Leon that this issue will be discussed with Dr Cavanagh tomorrow at his meeting. Leon expressed that he was having difficulty sleeping at nights and that the night sedation he is receiving is not making any effect. Leon appeared tired although settled and good humoured throughout the session. He expressed that he is not currently experiencing distressing thoughts but is worried about financial problems which face him when he returns home.	St. Andrew
20.09	Mrs Gratton on the ward to visit Leon, requested to meet with myself S/N Drummond. Mrs Gratton was distressed at the manner in which Leon spoke to her, continuously challenging her on issues. Mrs Gratton was very upset throughout the meeting, offering that she finds it difficult coping with	

Patients/Client Name

LEON GRATTON

Unit/CHI Number:

Date: Time:	Multi Disciplinary Record of Important Information not held in Evaluation/Review/Variation Records etc	Signature
	Leon and is worried about when he will be discharged. Support and reassurances given.	SDS
20:30	Spent pm between bed-side and dayroom. Quiet in presentation. Had visit from mother, recorded above.	SDS
8.12.03 v/o	Leon settled in presentation this evening. He telephoned his mother and apologised for his behaviour earlier this evening. Leon retired to bed after his 10pm medication and appears to have slept well overnight.	P.Hitchin
20 10:50	Monitor mood and mental state ERROR SD. DR CAVANAGH'S MEETING:- • Monitor mood and mental state • No passes @ present, to be reviewed mid-week by Dr Cavanagh. • Informal	SDS
12:05	Prompted to rise from bed by staff to meet Dr Cavanagh. Expressed he had a good sleep last night. Spent morning in dayroom watching TV with fellow patients.	SDS
20:00	During the course of the afternoon and evening Leon has presented quiet and slightly disgruntled, voicing feelings of boredom. Received dept as per order, next due 15-12-03.	AMGogan
9.12.03 v/o	Leon much more settled this evening. Leon sat in staff's company and initiated conversations appropriately. Leon retired to bed around midnight and appears to have slept well. Leon complaining of mouth ulcers. Advised that this would be dealt with by medical staff in the morning and in the meantime he should gargle with salty water.	P.Hitchin
13:05	Throughout the am spent time in the day room; quiet but with responses to staff.	Plaza
15:00	Initial blood test of urine - trace protein, small bilirubin. Sent sent to lab for screening.	Asie N
20:35	LEON SETTLED IN PRESENTATION. APPOINTED MYSELF WITH PATIENTS RE URINE TEST AND BLOOD CESS TAKEN TODAY ADVISED THIS APPEARED TO BE FOR BASE LINE AS SAME WAS NOT DONE ON ADMISSION. ALSO GIVEN REASSURANCE THAT "VOICES" HE COULD HEAR IN DAY ROOM OF SOMEONE SHOUTING FOR HELP WERE IN FACT REAL NOT IMAGINED AS STAFF COULD ALSO HEAR THESE TOO.	epL

Patients/Client Name

LEON GRATTAN

Unit/CHI Number:

Date: Time:	Multi Disciplinary Record of Important Information not held in Evaluation/Review/Variation Records etc	Signature
10.12.03 w/o	Settled evening and appears to have slept for long periods Tummy Misting - Showing improvement in mental state - Less hostility voiced towards his mother - Expressing feelings & boredom whilst on the ward - Wish to like to or to alleviate share and provide structured activities to day - Sleep improved over past 3 days - Showing some irritability in AM, settling in afternoon - Problems - Continue present care - Plans as wishes - In AM Leon left early but returned to bed again, only rising again prior to lunch	PHH
9pm	Leon has appeared bright in mood this evening, that time in company of another male patient. no concerns expressed	PHH
12.12.03	Went Spent evening in sitting room before retiring to bed, prn Zopiclone given at 2200hrs, appears to have slept soundly	J.R.
13.10	Up at 10am. Spent time socialising with others in the dayroom. No problems noted	ENAFord
20.36	Remains settled went to cafe with Derek Angus cot appears to have enjoyed same	PHH
12.12.03	NR Leon has slept very little overnight, despite receiving Zopiclone 15mgs at 10pm. Settled in presentation and pleasant in manner. Leon is invasive of staff's space at times last night and at times his conversation had guards directed at one particular member of staff	PHH
12.45	Pass medo ordered for overnight pass 13th - 14th. Appearing quiet, settled in demeanour within the dayroom	PHH
14.45	Settled in presentation, conversation appropriate. Accompanied staff to shop. Pleasant in manner throughout	PHH
13.12.03 06.30	Settled evening, spent watching T.V. before retiring to bed, P.R.N Zopiclone given 15mgs and has slept well overnight	PHH
11AM	LEFT WARD ON PASS DUE TO RETURN 14/12/03 AT 9pm PASS MEDS SUPPLIED	PHH

Patients/Client Name <u>Leon Gration</u>	Unit/CHI Number:
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Date: Time:	Multi Disciplinary Record of Important Information not held in Evaluation/Review/Variation Records etc	Signature
11.10	Leon's mum spoke to O/C/N Gibson requesting an appointment with DR. Cavanagh to discuss both diagnosis & psychology.	C Payne
19.30	KLW met with Leon to ascertain how his pass went. Initially he says "fine". He then went on to describe how he had been "hearing voices" especially that of his ex-partner - whom he believed to be in a room above his "Shagging" his neighbour. He then expressed derogatory thoughts, beliefs re: ex-partner and then his mother. spoke of still feeling paranoid and elaborated upon this of how "they" control his mind and time spent with his son. felt they were after him and how this was connected to his ex-partner & if he saw her he would "rip her face off" & harm her. He did appear to be responding to the T.V. in the dayroom at tea-time. Leon spoke of coping with this by lying on his bed. Does not appear to have been sleeping well, claims his sleep pattern has been disturbed due to the voices.	C Payne
12.05	Spent time within the dayroom socializing with fellow patients late evening. Had a carry out meal delivered which he shared with fellow patients after which he returned to bed. Appeared to have settled and slept well overnight.	J. Glos
11.00	Seen by DR. Cavanagh this morning:- - Commenced regular dosage of Haloperidol 2mg Q.I.D. - Due to current mental state. - No discharge date at present. - KLW to contact Leon's mum re: meetings regarding Leon's care. Leon happy to have her involved & information to be discussed in front of his mum at meetings. - Depot due today.	C Payne

Patients/Client Name

LEON GERTON

Unit/CHI Number:

Date: Time:	Multi Disciplinary Record of Important Information not held in Evaluation/Review/Variation Records etc	Signature
	During the course of the AM Leon has presented generally quiet within the ward. When in discussion with Dr Cavanagh, Leon made no reference to any details as documented for discussion with his last evening.	Dr Cavanagh
18.50	Depot given as per kardex, next due on Monday 22nd December.	Dr Cavanagh
20.30	Met with Leon's mum at her request and with permission of Leon. She was expressing her concern regarding Leon's mental state and the lack of improvement with Same. She also spoke of his pass home and how she had found him to be unmotivated with his son, wishing to stay within his flat on his own and wishing to remain in bed. Third party information Leon's mother has been informed by her sister that Leon had called his aunty last and stated that he would not get better until she (mother) died. Leon's mother has also found swords and ninja throwing stars whilst cleaning Leon's flat. She advised that Leon is unaware of her knowledge of Same and has not confronted him on these matters. Leon was brittle towards his mother whilst visiting this evening. Pleasant and appropriate whilst in staff's company but was overheard to be brittle in manner towards his father on the telephone.	Dr Cavanagh
18.12.03	Settled evening spent socialising and partaking of carry out meal. Reluctant to retire, eventually did so at 2300, and has slept well since.	J. Paul
12.50hrs	No change in presentation, socialised freely with fellow clients.	R. Boyce
14.30hrs	Seen by DR Ho, experiencing auditory hallucinations voicing hostilities towards mother. DR Ho feels Leon mental state has deteriorated. Now only allowed short unsupervised passes within hospital grounds.	S. [unclear]
17.40	In the late afternoon Leon approached staff voicing his displeasure at being inpatient, requesting to be discharged. Due to this request, met with Dr Ho. Outcome of this	

Patients/Client Name

Unit/CHI Number:

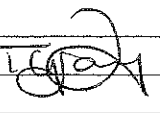
LEON GRATTON.

Date: Time:	Multi Disciplinary Record of Important Information not held in Evaluation/Review/Variation Records etc	Signature
	meeting is as follows: • Tired of being on the ward • Feels people are making fun of him, but won't state any specific incidents • Denies any intent to harm his mother • Reports that his swords at home are for collection purposes only. • Denies any auditory hallucinations except for ? hypoglycaemic auditory hallucinations last night • Not detainable • Accepts to stay inpatient at present • Agreed for sht pass on Thursday => Friday; and Sunday => Monday, if mental state does not deteriorate Since this discussion Leon has made no more reference to wishing discharge, and has spent time in the company of others in dayroom.	AGraham
4.55pm	Requested and given paracetamol 1 gram for rib pain at 13.15 hours with good effect.	SLanthers
17/12/08	Settled evening spent playing cards in dorm.	
07:00	and has slept well overnight.	C.Reid
12.35	MDL Lannanash team meeting	
	• Admitted to DR MD yesterday, to be experiencing auditory hallucinations. • wishes DR Lannanash to meet with his mother in his ^{present} presence • parent as already planned • not detainable, however persuade to stay if possible, if wishing to leave Late to rise, presenting as generally settled and socialising well with others	SLanthers
2000	During the course of the afternoon and evening Leon has displayed no change to mood and mental state. Time spent within the ward in the company of fellow clients. Requested to meet Dr Ho, complaining of a painful arm. On investigation no injury noted.	DMGage
18.12.08	Spent the evening playing cards with fellow clients. Retired and slept well.	J.Bender
1200	In the mid AM Leon collected his pass medication and left the ward planning to return tomorrow.	DMGage
19/12/08	Returned from pass as planned, reports that pass had gone new.	Rhipps
1935	Leon requested to meet with myself prior to going	

Patients/Client Name

Unit/CHI Number:

Leon Grattan

Date: Time: 19/12/03 Cont'd	Multi Disciplinary Record of Important Information not held in Evaluation/Review/Variation Records etc	Signature
	on pass. He expressed feelings of paranoia and delusional belief, stating he was constantly fighting with a Tai Chi master and that he was experiencing feelings of being raped. Stated he could smell the sperm and feel the penetration and sperm. Leon further went on to explain that he believed he had been raped in 1996. He believes this did happen but there was never evidence of same. Leon stated that this may have been a delusional thought, however he states that the feelings and smells are so strong that he is convinced this did happen. He has attended Abuse not in the past but stated that this made him feel angry. Leon also spoke of the Tai Chi master and was encouraged to discuss his passion of weapons. He stated he had a dagger in the home but refused to admit to any further weapons stating he had disposed of items he previously had owned. He also spoke of his anger he felt towards his mother stating he felt she took his ex partner's side. Leon was encouraged to reconsider his weekends pass, due to his current feelings and how the weekend had gone last week, however he was insistent on going as he was seeing his son; advised to contact ward if he required support or to return to the ward if he was unable to cope with being at home. Left message with WF cot to request a visit over the weekend. Pass made supplied. Leon's due to return Monday 22nd December @ 9am for Dr's meeting.	
20.12.03	Leon's mother contacted ward to express concern that he is low in mood over weekend. Feeling anxious that Haldore have not arrived. I contacted Leon and spoke to him. Gave reassurance that the team would visit him as this had been arranged. Leon says he is listening to music and plans to watch a DVD tonight. Advised	

MEDICAL - IN CONFIDENCE

ADMISSION DETAILS

UNIT/CASE REF. NO: []

CHINO []

Surname <u>GRATTON</u> Forename <u>LEON</u> Title <u>MR</u> Initials _____ Previous Surname _____ Marital Status <u>DIVORCED</u> Date of Birth <u>17.3.75</u> Sex <u>(M/F)</u> Address <u>85 SPITFELD RD</u> <u>INVERKEITHING</u> Post Code <u>KY11 1DZ</u> Have you been resident in the UK for the past 12 months? Y/N <u>Y</u> Religion <u>BUDHIST</u> Occupation <u>UNEMPLOYED</u>		Next of Kin or Responsible Party _____ Name <u>HORNA ALLAN GRATTON</u> Address _____ Tel. No. <u>01383 510096</u> Relationship <u>MOTHER</u> Emergency Contact _____ Name <u>GARY GRATTON</u> Address <u>57 ORCHARD BRAE</u> <u>MANCHESTER</u> Tel. No. <u>0161 7761420</u> <u>FATHER</u>	
G.P.'s Name <u>GARMMA</u> G.P.'s Address <u>INVERKEITHING</u> <u>HEALTH CENTRE</u> Admitting Ward <u>ROTHES</u> Date of Admission <u>12/3/07</u> Time of Admission <u>02 10</u> hrs CONSULTANT <u>DR FEE</u>		Status on Admission: <u>(A)</u> Voluntary (B) Respite (C) Compulsory If Compulsory state: Act _____ and Section: _____ Start: Date ____/____/____ Time ____ hrs End: Date ____/____/____ Time ____ hrs Emergency Admission? Y/N <u>N</u> Next of Kin to be notified? Y/N <u>N</u> Admission precipitated by self-injury/poisoning? Y/N <u> </u> Previous Psychiatric In-patient Care? Y/N <u>Y</u> Hospitals of Previous Admissions: <u>Ward 2 QWH</u>	
ADMISSION REFERRAL FROM: <u>9</u> 1. Psychiatric Out-Patients 2. Psychiatric Day Unit 3. Transfer from other Psychiatric IP Care 4. Non-Psychiatric Clinical Ward 5. From Extended Pass/Leave of Absence 6. Prison / Penal establishment 7. Judicial / Court 8. Local / Regional Authority / Voluntary Agency 9. Other A. Community Health Services Team B. Self / Relative / Friend C. Domiciliary Visit D. GP		ADMISSION TRANSFER FROM: <u>40</u> 11. Private Residence - living alone 12. Private Residence - living with relatives or friends 13. Private Residence (sheltered) - living alone 20. Usual place of residence: Institution, no additional detail added 22. Local Authority/Voluntary-Nursing/Residential/Hostel/Group Home 23. Private - Nursing/Residential/Hostel/Group Home 30. Temporary place of residence, no additional detail added 33. Legal Establishment, including Prison 34. No fixed abode 40. Transfer from same Provider Unit, no additional detail added 4B. Geriatrics (except for patient on pass) 4D. Psychiatric (except for patient on pass) 50. Transfer from other NHS Provider Unit, no additional detail added	
ADMISSION TYPE: <u>10</u> 10 Routine Admission, no additional detail added 12 Patient admitted on same day or following day as attendance at Outpatients, not for medical reasons but because suitable resources are available 18 Planned transfer 20 Urgent admission, no additional detail added 21 Patient delay (for domestic, legal or other practical reasons) 22 Hospital day (for admin. or clinical reasons, e.g. arranging appropriate facilities, for test to be carried out, specialist equipment etc.) 30 Emergency Admission, no additional detail added 31 Patient Injury - Self Inflicted (Injury or Poisoning) 38 Other Emergency Admission (inc. Emergency Transfers)		ADMISSION REASON: <u>50</u> 50 Psych. Admission, no additional detail added 52 Therapeutic/Clinical Crisis 53 Self Inflicted Injury 54 Poisoning 55 Accidental Injury 56 Other Injury 57 Rehabilitation 58 Other Type of Psychiatric Admission 5A Admission after Extended Pass 5B Respite/Holiday Care	

ON COMPLETION PLEASE RETURN TO MEDICAL RECORDS

MS910

Observation Care Plan - GENERAL

Patient's Name LEON GRATTON DOB 17/3/75 CHI/Unit No.
Ward ROTHES Responsible Consultant 17.3.75

Physical Description

Weight	14 st	Hair	brown / short.
Height	6' 2"	Build	medium
Weight		Dist. Features	tattoos both arms chest, shoulders.
Eye Colour	blue		

GENERAL Observation Level

The patient's general whereabouts should be known at all times, whether in or out of the ward. Particular note should be made at the start and finish of each shift and at key times such as mealtimes and medicine rounds. To be reviewed at intervals determined appropriate by the patient's primary nurse.

Reason for level / Specific risks identified

Low mood suicidal ideation
11/3/07 suicide attempt (overdose)

Specific interactions and limits to be applied

~~No time out to allow a period
of assessment.
To be reviewed by medical staff
if wishing to leave.~~

Prescribing Nurse Signature C. Spencer Grade S Date 12/3/07

GENERAL observation level raised to: CONSTANT / SPECIAL (delete as required)

Nursing Signature Date

Medical Signature Date

(Note: A medical signature is not essential when raising the observation level)

Review Notes Overleaf

REVIEW NOTES

Date	Observations / Decisions	Nurse's Signature
13/3/07	Escorted time out following negotiation with staff.	S. Mc

Mental Health Directorate
ADMISSION INFORMATION SHEET [A1-1]



Initial admission to Ward/Department: ROTHES	Community Service/Hospital: WBH	Date 12.3.07 Time 02:10
Consultant: FEE	Named Nurse/Case Manager: S/N MORAG DEAS	Unit No/CHI No
		Care Programme Approach No

Personal Information

FULL NAME: ☒ Mr / ☐ Mrs / ☐ Ms / ☐ Miss / ☐ Master LEON GRATTON	Where appropriate, likes to be known as: LEON	Previous or Maiden Name(s) ←
Home Address 85 SPITALFELD RD INVERKEITHING	Date of Birth 17.3.75 Gender MALE	Place of Birth 17.3.75 MANCHESTER
Post Code KY11 1DZ	Current Address ← Post Code	Marital Status DIVORCED Telephone No(s)
Present/Past Occupation UNEMPLOYED	Religion and/or Chaplaincy requirement BUDDHIST	Ethnic Origin Sensory Impairment problem (s)
Allergies NONE KNOWN	Is English first language? Yes ☒ No ☐ Preferred Language	Is an Interpreter required? Yes ☐ No ☒ Name (relationship to client, if any)
MHA Status INF	Review Date Patient Informed of Status By: Date:	Clinical Risk Yes ☐ No ☐ If yes; Specify Main Risk Refer to Care Plan No _____
		Does the Adults with Incapacity Act Apply; Yes ☐ No ☒ Is there an Identified Relapse Signature? Yes ☐ No ☒ If Yes; Refer to Care Plan No _____

Main Carer/Partner/Relatives/Named Person Information etc

(1) Full Name LORNA GRATTAN	Home Address NOT KNOWN Post Code	Telephone No. 01383 510096 Relationship MOTHER
(2) Full Name GARY GRATTAN	Home address 57 ORCHARD BRAE MANCHESTER Post Code	Telephone No 0161 7761420 Relationship FATHER
Does service user agree with the sharing of information with Carer / Nearest Relative / Partner Yes ☐ No ☒	Identify person to be contacted if patient is sick, dying or in any emergency. MOTHER / FATHER	Where appropriate - Order of Contact MOTHER

Mental Health Directorate
ADMISSION INFORMATION SHEET [A1-1]

Patients Name Unit/CHI No

Diagnosis

Relevant Medical Condition: 	Medication Concordance: POOR depot depot 3mg weekly
--	--

Community Service Involvement

	Name/Address	Tel No's
LMHT/Community Team		
General Practitioner	DR. [unclear] INVERKENTING H/C	
Social Worker		
Community Psychiatric Nurse	TOM SHIRT COT. HOLDANE HOUSE	01383 432725
District Nurse		
Care Programme Approach Co-ordinator		
Home Care Manager		
Chaplain		
Dependants		
Other involvement Ri	RICHMOND SUPPORT	01383 622133

Patient Financial Information etc

	Where appropriate - Name/Address	Tel No's
Welfare Power of Attorney:		
Power of Attorney/Guardian/Curator:		
Pension Book etc held by:		
House Keys held by:		
Insurance Number:	NI -> JC 49 65 64 A	
Advanced Statement held at/with		

Nursing Observations

Temperature 35.7°	Pulse 82	Blood Pressure 120/86
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Signature of Person Completing this Form:

Date:

Working With Risk (1): Current Situation (RA1)

 Name: Leon Gration Date of Birth: 17/3/75 CHI/Unit No:

 Address: 85 Spitalfield Road Inverkeithing

 Post Code: K41 1DZ Gender: Male

Date of Assessment: / / Time: Review Date: / /

Category of Risk
Assessment of Risk
From Others (e.g. abuse, exploitation)

Yes / No / Unknown

Details of identified Risk:

To Self (e.g. suicide, self harm)

☒ Yes / No / Unknown

 Details of identified Risk: 11/3/07 - OD attempt (semi-impulsive act)
continues to experience fleeting suicidal thoughts
however no plans feels safe in hospital.
To Others (e.g. aggression, violence)

Yes / No / Unknown

Details of identified Risk:

Neglect (e.g. health, personal appearance)

☒ Yes / No / Unknown

 Details of identified Risk: Low mood - depressed appetite
To Child(ren) (e.g. neglect, abuse)

Yes / No / Unknown

Details of identified Risk:

Physical Impairment (e.g. medical, sensory)

Yes / No / Unknown

Details of identified Risk:

Wandering & / or Falls

Yes / No / Unknown

Details of identified Risk:

Memory and Cognitive Impairment (e.g. forgetfulness)

Yes / No / Unknown

Details of identified Risk:

Challenges to Services (e.g. inappropriate demands, poor compliance)

Yes / No / Unknown

Details of identified Risk:

Risk Taking Potential (e.g. positive resources, agreed plans)

Yes / No / Unknown

Brief details:

Patient Name..... CHI/Unit No.....

Significant Known History (include known diagnoses & examples of risks taken):

.....

Initial Assessment of Risk (including context, situations in which risk may occur and positive resources, potential for positive risk taking).....

.....

Initial Risk Management Plan (including who is responsible for what, identifying potential for risk taking):.....

.....

Sources of Information Available for this Assessment:.....

.....

In What Way Has This Assessment Taken Place?.....

.....

Involvement and/or Agreement of Patient and/or Carer In Plan:

Comments:.....

.....

Need For More Detailed Risk Assessment & Management:

YES

NO

Completed By:.....Date:.....

Discussed With:.....Time:.....

~~Fife Primary Care NHS Trust – Mental Health Directorate
Care Notes – Continuation Sheet [CN1B]~~

Patients/Client Name

Unit/CHI Number:

LEON GRATTON

Date:	Record of Important Information not held in Evaluation/Review/Variation etc	Signature
12/3/07	Interviewed by Dr Borkson Requires further period of assessment Request notes from GMB ✓ Confirm when depot was last given and clarify other medication Tom Short from community Outreach Team has been collected Return call from Tom Short who confirmed that heon was on depot of Clopixol 3mg weekly and last given 22/12/07.	Wilkes
3/3/07	Dr Howes contacted GP and confirmed dose of Nitrazepam Phone call from Tom Short to state that depot is depixel 3mg weekly. Also can't attend Thursdays ward round -	Wilkes
19/3/07	CLINICAL MEETING - following discussion with Dr Cavanagh Dr Borkson has advised heon that he will be discharged today with follow up as per COT care plan with Dunfermline Team. Dr Borkson will contact heon's mother. Tom Short CPN informed of discharge and date of depot injection Rehmanul Siddiqui informed of discharge	Wilkes

Hospital: Whittemans Braie Ward/Dept Rother

[illegible]

Fife Primary Care NHS Trust – Mental Health Directorate

Continuation: Page 2

Name: _____ Unit/CHI No: _____

[illegible]

Ward /Dept ROTHES WBH.

Name: <u>LEON GRATTON</u>		Care Plan Number 1	
C.H.I. Number	Unit Number	Date Commenced <u>12/3/07.</u>	
Consultant/G.P. <u>FEE</u>	Prescribed By Named Nurse: <u>SIN MORAG DEAS</u>	Date Resolved	
Description of Need: Client is experiencing an altered mental state requiring admission to hospital for admission			
Objective/Expected Outcome To complete a nursing assessment of the client's mental state from admission, thus providing a basis for the formulation of the care particular to the client's need			
Actual Outcome			

Evaluation/Review No	Date Due	Evaluation/Review No	Date Due
1	<u>17/3/07.</u>	6	
2		7	
3		8	
4		9	
5		10	

Fife Primary Care NHS Trust - Mental Health Directorate
Acute Inpatient - Admission to Hospital [F1]

Patient/Client Name _____ Unit/CHI No _____

ACTION TO BE TAKEN: - CARE PLAN – Admission to Acute Ward	Date	Signature
1. Implement observation level as prescribed by multidisciplinary team in accordance with Trust /hospital policy and procedure. 2. Observe client's behaviour, social interactions and participation in activities. 3. One to one patient interactions enable collection of information on the client's mental state and the problems that they perceive. 4. Liaise with members of the multidisciplinary team regarding client's mental/physical status. 5. Administer medication as prescribed. 6. Report and record all observations and any information gained from patients interaction accurately 7. Liaise with carers and relatives to gain a comprehensive profile of presenting problems 8. <i>Individual Nursing Actions Required: -</i>		

Discuss plan of care with Patient/Client and if appropriate their Relative/Carer. Where appropriate ask the patient to sign that they agree /disagree with this care plan. If you do not ask for acceptance please record reason in 'Care Notes'

I have had the care plan explained to me and I do/do not wish this to be initiated:

Patients/Client Name **NEON GRATTON**

Unit Number / CHI

Date of Birth **17.3.75**

Named Nurse/Key Worker **SIN MORAG DEAS**

Date: Time:	Multi Disciplinary Record of Important Information not held in Evaluation/Review/Variation Records etc	Signature
12/3/07 (02:00)	<u>Informal admission of this 31 year old gentleman following self-presentation to Accident and Emergency. Leon sought medical attention after taking an overdose of Lorazepam 25mg x 10 tablets and paracetamol 8-10 tablets. Leon known to Psychiatric Services with previous admissions to ward 2 Queen Margaret hospital. Transferred to Rother ward due to lack of Beds in Ward 2.</u> <u>Presenting Complaint</u> Leon stated his mood has been low for past 2-3 weeks experiencing fleeting suicidal thoughts, and automatic negative thinking "lifes not worth living" "fed up with life" "would be better off dead". Impulsive overdose attempt when at home (11/3/07) contacted The Samaritans who advised him to Attend Accident and Emergency. Leon self presented at A+E and following psychiatric Assessment was admitted informally to Rother ward. <u>Past Psychiatric History</u> Known to psychiatric Services previous admissions to ward 2 Queen Margaret hospital. Attends Out patient clinic - Dr Caragh last seen him 2 months ago. Seen by Dr Lehany 2 weeks ago reduced Depot Dose at this time CPN - Tom Short. Diagnosis - Schizo-affective Disorder Borderline Personality disorder. <u>Social History</u> Lives alone in council flat receives Incapacity Benefit and DVA, Denies the misuse of illicit substances and stated he drinks alcohol on occasion not a regular drinker. Smokes 40 cigarettes per day.	

Patients/Client Name Leon Gratton

Unit/CHI Number:

Date: Time:	Record of Important Information not held in Evaluation/Review/Variation etc	Signature
12/13/07 (Cont...)	Leon has two sister living in Manchester not a close relationship with sisters or father who also lives in Manchester. Mother lives closer to Leon although Leon stated they too do not have a close relationship. Leon feels his mother "Puts him down all the time". <u>Forensic History</u> Leon stated he has attended court due to punching his mother in the nose. Leon presented - casually dressed unshaven although suggested growing a full beard average self-care, good eye contact throughout admission interview no further suicide plans at this time denied any perceptual disturbance stated experiencing auditory hallucinations "from time to time" last experienced same 4-5 weeks ago stated he "Can't handle them" Denied taking overdose due to voices commanding him. Stated he has not been eating well and sleeping up to 12-14 hours has missed last two depot injections (Clopixol weekly). Leon spoke of his grandmother's death 4-5 weeks ago and feels same has had an effect on his current mood limited family support. <u>Plan</u> * Informal admission - Period of Assessment * Review by medical staff if wishing to leave. * Physical, Kordex, bloods. Done at QMH * ECG done - normal * Transfer to Ward 2 when bed available.	
(04.00)	Retired to bed and appears to be resting	C Spru C Spru

Patients/Client Name Leon Gratton

Unit/CHI Number:

Date: Time:	Record of Important Information not held in Evaluation/Review/Variation etc	Signature
12/3/07	Leon has been quite restless initially asking for discharge but has since agreed to remain for further assessment of mood was visited by his mother	
12/3/07	Received 20ml of Malarx at 13.30	W. Gibson
15.10	for heartburn P.R.N. -	W. Gibson
16.40	Complained of feeling dizzy, advised to rest at bed area BP 119/55 P 81 lying BP 102/72 P 116 standing. Given advice on control of anxiety symptoms	W. Gibson
20.00	No further reports of panic attacks and appears more settled although has kept his own company	W. Gibson
13/3/07	Leon retired to bed at 01.00h. Slept well until 04.45. States he would like to stay in Robs as opposed to Q.M.H. appears settled.	W. Gibson
13/3/07	Phone call from Dr. Boulton who has	W. Gibson
14.30	liased with Dr. Casanueva at Ward 2 during the night. Leon's overdose appears to have been a reaction to receiving a phone bill for £500. He has apparently been texting a girl or girls. His mental health has been deteriorating for a couple of months and he has been threatening people and threatening them (Persons unspecified). He has been described as a difficult patient who has a good support package and tends not to be admitted to ward 2 but gets dealt with in the community. Dr. Casanueva recommended that if Leon is not suicidal then it may be relevant to discharge him. Dr. Boulton would like to receive medical notes prior to discharging.	W. Gibson
13/3/07	Leon requested PARACETAMOL 1000mg at 12.35 for purpose of alleviating a headache.	W. Gibson
15.00		W. Gibson
13/3/07	Phone call from Tom Short, Leon's depot injection is defixol 30mg weekly, also stated that he can't make Dr. Boulton's clinical meeting	W. Gibson
17.45		W. Gibson

Patients/Client Name	Unit/CHI Number:
LEON GRAFTON	

Date: Time:	Record of Important Information not held in Evaluation/Review/Variation etc	Signature
3/3/07 17:45	also stated that this is Leon's first admission for a few years. Leon also apparently panicked regarding Boyle breaking into his house.	Sh. Lul
20:30	Visited by his parents this evening and noted to be very volatile with his mother. claims that he is not getting sufficient help for his anxiety symptoms and despite reassurance began voicing paranoid ideation expressing concern that his flat is unsafe and has also been preoccupied with thoughts that ex girlfriend will be raped. Settled for a short period once parents left but later approached staff appearing angry and tense. Requested and received horezepam ing at 20:30hrs	W. Deas
14:30 00:50	Leon requested and received 1 gramme paracetamol for headache at 00:45h as per Kardex.	bStewartson
14:30	Leon has not gained much sleep overnight spent most of it in smoking sitting room. appeared to be responding to auditory Hallucination after staff hearing a outburst from Leon in sitting room at 04:15h retired to bed at 04:45 asleep at time of written report.	bStewartson
11:45	Visited by Richmond Support Worker and taken out to bank	W. Deas
14/3/07 14:30	Depot administered to left side as per Kardex.	Sh. Lul
14/3/07 19:30	Leon has spent most of the evening with fellow patients in the smoking room, apart from a supervised trip to the shop. Behaviour has been mostly appropriate, however was observed gesticulating in the smoking room as if in an argument with thin air or an hallucination. Was also overheard in a heated conversation with someone on the telephone. No issues arising from same. Settled at time of writing.	Pr. BA JIM B. FOUR
15/3/07	Leon offering no complaints this evening remains settled around ward has slept well overnight.	M. K. H.

Patients/Client Name

Unit/CHI Number:

Leon Gratton

[illegible]

Patients/Client NameUnit/CHI Number:[illegible]

Occupational Health and Safety Advisory Service / January 2002

Client Handling Assessment Form

A. Client Details/Assessment

A. Client details

Leon Gratton
85 Spitalfield Road
Inverkeithing
KY11 1DZ

Date		
Weight kg:		
Height mtrs:		
BMI		

Weight Bearing: ☒ yes ☐ no

☒ Full ☐ Partial ☐ variable

History of Falls: ☒ yes ☐ no (please circle)

Equipment used by client:

wheelchair	stick
hoist	other
zimmer	
rollator	

Physical condition

Client's comprehension / communication

Handling constraints:

Behaviour which may effect safe handling:

Rehabilitation Programme:

Action plan discussed with client/carer yes/no

Date:

Signature:

Designation:

[illegible]



Mental Health Risk Assessment Checklist



Patient/Client Name

LEON GRATTON

Date of Birth

17/8/75

CHI/Unit No

1191

Past History

History of Violence (ever)

- None home
One incident
Two incidents
Three incidents
More than three incidents

Tick

☐
☐
☐
☐
☒

Most serious harm caused

- None
Minor injury
Serious injury
Fatality

☐
☒
☐
☐

History of Suicide attempts (ever)

- None
One
Two
Three
More than three

☐
☒
☐
☐
☐

History of severe self neglect (ever)

- No ☐ Yes ☒

History of risk to children (ever)

- No ☒ Yes ☐

History of containment (ever)

- State Hospital
Secure Care
Prison
CU/Locked ward
Compulsory Admission
Temp Detention at Police Station

No	☐	Yes	☐
No	☐	Yes	☒
No	☐	Yes	☐
No	☐	Yes	☐
No	☐	Yes	☐
No	☐	Yes	☒

Incidents involving the Police (past year) (ever)

- None ☐
One ☐
More than one ☒

History of failure to take medicine

- No ☐ Yes ☒

History of unplanned cessation of contact

- No ☒ Yes ☐

Known Problems over the last year - ever

Tick all problems presented (in past year) (ever)
Accident harm at home (eg, falling, careless smoking) ☐ ☐

Accident harm outside the home eg, wandering into road ☐ ☐

Alcohol abuse ☐ ☒

Arson (deliberate fire-setting only) ☐ ☐

Drug abuse ☐ ☒

Overdose ☐ ☐

Risk of abuse from others ☐ ☒

Risk to children ☐ ☐

Self-injury (eg, cutting) ☐ ☐

Other methods of self harm (specify).

Self-neglect ☐ ☐

Sexual Assault ☐ ☐

Violence to family ☐ ☒

Violence to staff ☐ ☐

Violence to other patients ☐ ☐

Violence to the general public ☐ ☐

Violence to specific other ☐ ☐

Other (specify) MOTHER

CAN BE AT RISK
FROM LEON, ALSO
LEON'S STEPFATHER

Patient/client name LEON GRATTAN CHI/Unit No

Detail of nature of risk:

- o POOR STRESS CONTROL / IMPULSIVE BEHAVIOUR
- o ABOVE? MIXED WITH ALCOHOL CONSUMPTION
CAN LEAD TO AGGRESSION
- o CAN BE OVER FAMILIAR / INNAPPROPRIATE IN
MANNER TOWARDS FEMALE STAFF.

State sources of information, who consulted and relationship to patient/client

- o NURSING / MEDICAL NOTES
- o RELATIONSHIP WITH LEON.
- o C.P.A. MEETINGS
- o FAMILY

Further Level of Assessment Required No ☐ Yes ☒ Specify WHEN REQUIRED

Plan of Action

Date time of completion 1.8.06

Name in Block Capitals TOM SHORT

Designation C.C.M.

Signature T. Short

Fife Acute Operating Division	Queen Margaret Hospital
Clinical Neurophysiology EEG Dept. Outpatients Department	Leon Gratton
Victoria E.E.G Dept	CHI 17.03.75 Sex: Male
Factual Report	E.E.G Number V6262
	Date of report 14.07.04
	Date of test: 26 06.04

Clinical History:

This patient suffers with blackouts.

Factual Report:

The EEG revealed a fairly well formed dominant postcentral rhythm at 8-9hz and this activity was intermixed with some slow waves. Widespread low voltage fast activity was seen with an even distribution over all areas. Moderate amounts of rhythmical regular theta waves were seen fluctuating over the central and temporal leads.

Myogenic potentials were seen when the patient was fidgety.

Activation procedures were unremarkable on this occasion.

Miss Louise O'Shea
Chief Technician
Victoria Hospital
Kirkcaldy.

Conclusion:

1. A normal EEG.

Dr. K.M. Spillane
Consultant Neurophysiologist
St James Hospital
Glasgow

