

TO BE COMPLETED BY MHS REHABILITATION STAFF ONLY

ASSESSMENT INTERVIEW (R2 RS-1B)

Assessing Nurses Kenny Thomson = N + Carol Ann Smith & Ward + FALKLAND LINDORES

Date 13/10/11

Points of Note from Referral

Leon states he is happy to come to Stratheden. Feels it would be a step forward to getting back into community. Requesting PRN paracetamol regularly (says it's for toothache/headache) but also says he's worked up/stressed about mother's illness (obsessed). Pushes bandaniers within the ward. Loud at times throughout the night, Laughing out loudly. Openly responding. Turning night into day. Has refused 8am meds x 3 this week. Only passes out are to cash girls. Does not want to go back to own house (Drug dealers handling him). Could not initiate what he wanted to achieve from rehab. Had to ask what's an offer then stated happy to do same. No set goals. Heavy lorazepam/proprylidone use on last admission Apr/May 2011.

Concerns from Risk Assessment

Admits to using large amounts of ecstasy recently. Vulnerable to exploitation from others. Previous physical violence to others when unwell or under influence of alcohol/illicit substances.

Recommendations and Reasoning

Staff assessing Leon feel he is not at a point where he is ready to actively go through the rehab process. Does not have any goals for himself. Happy to go along with what we said was on offer. Mental state appears disoriented in conversation. Appeared very uneasy/unsettled throughout assessment. Mood appears stable. Definitely not ready for Dinning Ward. Impulsive in behaviour and staff assessing feel Leon would perhaps be a poor influence on certain patients within Falkland and could also be led into vulnerable situations himself. Currently lacks motivation to actively engage in therapies.

Completed By

Kenny Thomson S/N

Date Discussed at Clinical Rehab Meeting

Outcome

Leon Gratton 6 week assessment

Informal: time out has been escorted to appointments

Medication:

Nitrazepam 10mg x 1 22:00

Citalopram 20mgs x1 08:00

Omeprazole 20mgs x1 08:00

Pizotifen 1.5 mgs x1 22:00

Paracetamol 1 gm x 4 08:00, 13:00, 18:00 and 22:00

Trifluoperazine 10mgs x2 08:00 and 22:00

Prn diclofenac sodium 50mgs and haloperidol 5mgs utilised frequently.

Using diclofenac for 'headaches' at first and more recently has been asking for diclofenac for rib pain, dental pain, knee pain and back pain. Says he now realises that diclofenac is not really the drug for him as he does not have 'arthritis'. Wishes to change the anti-inflammatory for ibuprofen.

Seeks out staff constantly for 1.1's and is often talking about the following subjects/delusions/paranoia:

- Sexual abuse
- Grandfather is a paedophile
- Mother has interfered sexually with him and concerned that she is doing the same to his son
- Being raped
- Obsession with the Nazi's, the drug scene, gangs in Inverkeithing, Wester Hailes and other places in Edinburgh and Hell's Angels, Jimi Hendrix, Martial arts
- Patients stealing cigarettes from him
- Being drugged
- Elves and dwarfs are real
- Time in the care homes and friends and acquaintances he met whilst in care
- Time in the Royal Hospital, Edinburgh and QMH.

- Let son watch horror movies at age 3
- Believes cheques will be worth 'millions' so is thinking about keeping them for 'future prosperity'
- Believes he may have cancer, HIV and wounds to the head where he 'had a gash stapled'.
- Rubbish bins have been 'filled' and on swatting a fly it was full of human blood

Mental State:

- Hallucinations both olfactory and visual.
- Hears voices, mostly screams which can be 'people being crushed in car crushers' or 'just loud screaming of hundreds of people'.
- Laughs to himself and sometimes denies laughing or says that he is laughing 'like a mad man' (he often is in a sitting position in the corridor when he laughs)
- Paranoia about other patients stealing from him and about staff who are deliberately working against him (believes staff nurse Hynd has ripped up a letter of his from the DWP)

Vulnerability:

- Is known to hand out tobacco/cigarettes/money to people despite him not having enough for himself.
- Budgeting is not very successful but does have a post office account.

Leon's personal views:

- He likes the ward and feels 'safe' he says.
- He feels that his mental health has improved since he came here and he enjoys the time he is allowed for 1:1's with the staff.
- He still likes to write poetry and he enjoys reading, especially science fiction and fantasy. He has bought books whilst out shopping in Cupar.
- He does not want to keep his tenancy because he says he 'wants out of the drug scene'.

- He enjoys music and is hoping to have his mother bring some of his CD's to the hospital for him. He says he prefers music to television.

Physical:

- Leon sleeps an average of 5-6 hours through the night
- He has an eye appointment on 6 Feb in Cupar
- He has been attending the dentist and is still undergoing treatment
- Constantly complaining of headaches and various 'muscle pain'

Concerns:

- Smoking in his bed/bathroom
- Vulnerable with money and cigarettes
- Constant use of prn's

Kirkcaldy & Levenmouth CHP
Mental Health ServicesCurrent T2 T3:

NOT on T2 or T3

PRN Usage:Only on PRN Paracetamol for headache and
toothache.Current High Dose %Advanced Statement YES/NO
(if yes please specify)Named Person YES/NO
(if yes please specify)Advocacy Involvement YES/NO
(if yes please specify)

Jim NESS

Finances – Benefit/Amount/Frequency/Where paid into?/Med 10 Date Last Issued/Date
next due
(please specify)Income support 274.50 fortnightly, giro cheque
Disability living allowance 275 monthly, giro cheque

Kirkcaldy & Levenmouth CHP
Mental Health Services

Drug/Alcohol Intake: uses amphetamines, ecstasy and cocaine on
Type: regular basis.
Drinks alcohol occasionally, reported not consumed 2 weeks prior to admission
Frequency: see above

Drug Screen: YES/NO
(please specify)

Negative to all

Any other Relevant Information:

Please Remember to Enclose:

Please tick

O.T. Assessments

☐

Named Nurse Questionnaire

☐

Recent Risk Assessment

☒

Signed:

[Signature]

Print Name

Bayan Cliftmore

Date:

12/10/11

Kirkcaldy & Levenmouth CHP
Mental Health ServicesDate of Current Admission:

08/09/11

Current Mental State & Behaviours:

Since admission Leon has been generally settled in the ward, interacting well with staff and fellow patients. However, during 1-1 sessions with staff he has raised concern regarding past sexual abuse, fears over his mother dying due to poor health, believes his mother breathing problems are due to coven (curse) in waster flannels. He has reported on numerous occasions that there are spiders in his flat, that he has avoided being killed on numerous occasions. Has continued to request PRN medication, staff felt he did not need these. PRNs have been discontinued and has managed well without them.

Physical/Medical Issues:

No physical problems reported

Current Time-Out Status:

Leon is an informal patient, passes as wishes. However does not go out on pass due to fears of being harassed by drug dealers. Leon has reported that he has cleared his debts with them. ? Paranoid about this (intimidation)

Mental Health Services

Name

Leon Giffen

CHI/PIN No.

FS156833

1706751191

Summary of Assessment (General Overview of situation)

Leon reports using amphetamines, ecstasy, cocaine on regular basis. Takes food from bins of local bakers to eat. Intimidated by drug dealers. Has tenancy issues looking for new place. Can be over familiar with female staff. Home visit at home. Previous Numerous Overdose's.

Client involved

Yes ☒ No ☐

Carer Involved

Yes ☐ No ☒Discussed with other agencies: please specify ALG

Comments:

Other information obtained from previous documentation**If required, please continue on a continuation/evaluation sheet*

Completed By:

BC

Bryan Cliver

Date:

8/9/11

Time: 1:45 PM

Need For More Detailed Risk Assessment & Management:

NO

☐

YES

☐

If yes please go to RA part 2

Kirkcaldy & Levenmouth CHP
Mental Health ServicesREFERRAL TO MHS REHABILITATION SERVICES - (R2 RS-1)Patients Name: Leon CrichtonLegal Status: InformalDate of Birth: 17/03/75R.M.O.: Dr CavanaghCHI No: 1703751191S.W./M.H.O.: Fiona HunterReferring Ward: Ward 2 QMHCPN: Dawn Stanley WFCUTNamed Nurse: Liz DuffyDiagnosis: Schizophrenia / BPDReason for Referral:

It is felt that Leon would benefit from some time in Rehabilitation. He suffers from chronic symptoms of schizophrenia and problems related to his misuse of substances. He is currently living in appalling social circumstances and is clearly not coping in the community. He is not eating well, as spends his money on drugs. Since last discharge he has been taking food from bins of local bakeries and has suffered continued intimidation by drug dealers. He needs money.

Psychiatric History and Circumstances Leading To Current Admission:

Leon's most recent contact with services over the last few years is as follows. Recently he had an admission due to a deterioration in mental state due to drug misuse and also found to be losing weight. In Dec 2010 out patient appointment; complain of auditory hallucinations and somatic symptoms. In October 2009 he took an impulsive mixed overdose. In September 2009 he took an impulsive overdose of paracetamol and Sumatriptan, also in 2009 September he was brought in hospital by police as being responding to auditory hallucinations. In June 2008 he was admitted following a Paracetamol overdose. He described auditory hallucinations. Several admission to ward prior to these drug years.

Effe

Mental Health Services

Working With Risk (1): Current Situation (RA part 1)

Name: Leon Griffin Date of Birth: 17/03/75 CHI/PIN No:
 Address: 85 Spital Road
Inverkeithing Post Code: KY11 1DZ Gender: M
 Period/Date of Assessment: From 8/9/11 to 1/1

Complete any details of identified Risk below:	Assessment (Circle relevant answer)
From Others (e.g. abuse, exploitation) Leon vulnerable to exploitation. Appears to be easily led by others. Previous association with drug dealers. Spending time in his home. Leon appears intimidated by same.	No / Unknown / <u>Yes</u>
To Self (e.g. suicide, self harm) Impulsive behaviour, numerous overdose attempts. Use of illicit substances - admitting to use large quantities of ecstasy.	No / Unknown / <u>Yes</u>
To Others (e.g. aggression, violence) Previously violent towards mother and step father. Can be over familiar towards females on home visits (NHS).	No / Unknown / <u>Yes</u>
Neglect (e.g. health, personal appearance) Reported on 8/11 had no bath for 6 weeks, Dramatic weight loss.	No / Unknown / <u>Yes</u>
To Child(ren) (e.g. neglect, abuse) On 27/10/11 Reported by Barbara Barnes (child family social worker, that Leon had allegedly admitted to feeding sexually abused young children when he was younger 10 years ago. Leon questioned by police no further action taken.	No / Unknown / <u>Yes</u>
Physical Impairment (e.g. medical, sensory)	No / Unknown / <u>Yes</u>
Wandering & / or Falls	No / Unknown / <u>Yes</u>
Memory and Cognitive Impairment (e.g. forgetfulness) Auditory hallucinations, command in nature. Overdose previously, impulsive behaviour. Daily dispensing medication.	No / Unknown / <u>Yes</u>
Challenges to Services (e.g. inappropriate demands, poor compliance) Has made false accusation towards others. Can be over familiar with females. Sporadic attendance at depot clinic. Rarely attends O/P with Dr Cavanagh. Joint visits at home.	No / Unknown / <u>Yes</u>
Strengths/Positive Attributes (e.g. positive resources, agreed plans). Creative self published poetry, Creative writing.	No / Unknown / <u>Yes</u>

REFERRAL TO MHS REHABILITATION SERVICE

NAMED NURSE/QUESTIONNAIRE

Name of Patient: LEON GRATTON	CHI No:
Date: 13/10/11	Ward: TWO

	NO	YES	If Yes please add Comments
Does patient have a problem attending to Personal Hygiene Independently?	✓		Requires prompting
Does patient have a problem attending to Dental Hygiene Daily?	NO	YES ✓	He often forgets.
Does Patient require regular Dental Appointment?	NO ✓	YES	If appointment previously organised; Date Time.....
Does patient have a problem attending to foot care unaided?	NO ✓	YES	
Does patient require the attention of the Chiropody service?	NO ✓	YES	If appointment previously organised; Date Time.....
Does patient have an Optician Appointment?	NO ✓	YES	If appointment previously organised; Date Time.....
Does patient have a problem attending to own laundry?	NO ✓	YES	
Does patient have a problem attending to or require prompting to change clothes?	NO	YES ✓	Requires prompting to change clothes
Does patient have a problem rise without prompting?	NO	YES ✓	Requires prompting to rise.
Does patient spend much of the day in bed?	NO	YES ✓	as above. Claims he is bored.

Does patient use night sedation?	NO ✓	YES	
Any issues regarding sleep patterns?	NO	YES ✓	Turns day into night.
Does patient have any dietary requirements?	NO ✓	YES	
Does patient have a problem in being able to have varied diet (meals)?	NO ✓	YES	
Does patient have any allergies?	NO ✓	YES	
Does patient smoke?	NO	YES ✓	
Is patient a fire risk?	NO ✓	YES	
Is patient a specified person?	NO ✓	YES	
Does patient have a problem attending to budget appropriately?	NO	YES ✓	Was spending a lot of money on drugs in community, no money for food as a result.
Does patient have a problem participate in social activities?	NO ✓	YES	
Does patient have any communication difficulties?	NO ✓	YES	
Any other comments;			

Signed By: RAA wbg

Date: 13/10/11

Leon Gratin.
Ward 2.
QMH.

TO BE COMPLETED BY MHS REHABILITATION STAFF ONLY

ASSESSMENT INTERVIEW (R2 RS-1B)

Assessing Nurses Tanya Lonergan Ward Falkland ..
Date 3/12/11

Points of Note from Referral

Leon's mental state seems stable, some fixed beliefs but not distressed by these. Feels unable to return home as he is vulnerable to exploitation from others (drug dealers). Wants to come to Stratheden (informal patient), just starting to engage with OT's. Spends long spells in bed, no structure to his day, requires prompting with his personal hygiene. Sleep pattern improved, sleeping more at night but still in bed throughout the day. Smokes cigarette's, managing money better since in hospital. Eating well. Behaviour appropriate, not violent, irritable or disruptive. Taking medication trifluperazine 15mg's, nitrazepam 5mg's, Pizotifen (for migraines).

Concerns from Risk Assessment

Leon is vulnerable and has been exploited by others, said drug dealers would come to his house on giro day and take him to the bank, they would take his money and give him very little drugs, which he didn't even want.

- Hx of alcohol / drug misuse
- History of overdose.
- Hx of assault on mother / step father. No recent violence.

Recommendations and Reasoning

Ifelt Leon would benefit from a period within rehabilitation, so he can engage with therapies, add structure to his day and have stable mental health in a hospital setting for a longer period of time, away from drugs/alcohol. He would require help with personal hygiene, socialisation/social inclusion, budgetting and general household tasks such as cooking, cleaning, laundry.

Felt better suited to Donino.

Completed By

Lanya Lawergan SCN.

Date Discussed at Clinical Rehab Meeting

Outcome

To be offered six week assessment in Donino.

Donino staff to arrange transfer.

Client Handling Assessment Form

A. Client Details/Assessment

A. Client	F5153833
GRATTON, LEON 85 Spittalfield Rd Inverkeithing KY11 1DZ	
CHI: 1703751191; D.O.B. 17/03/1975	

Date	9/4/11	
Weight kg:	72kg	
Height mtrs:	1.86	
BMI	21	

Weight Bearing: ☒ yes ☐ no☒ Full ☐ Partial/variableHistory 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: 9/4/11

Signature: ASymer

Designation: SLN

Observation Care Plan - GENERAL

Patient's Name Leon Gratten DOB 12/3/75 CHI/Unit No. 1191 / F5153833
Ward 2 Responsible Consultant A. Caranagh

Physical Description

Height	<u>1.86</u>	Hair	<u>Short Brown</u>
Weight	<u>72kg</u>	Build	<u>Medium</u>
Eye Colour	<u>Blue</u>	Dist. Features	

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

to assess mood and mental state,

Specific interactions and limits to be applied

~~to pass at present~~
Escorted passes within hospital.

Prescribing Nurse Signature A. Syme Grade S/N Date 9.4.11

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

This Care Plan has been discussed and agreed (Patient signature) Date

Nursing Signature Date

Medical Signature Date

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

Ward /Dept

2

Name: Leon Gratton		Care Plan Number 1	
C.H.I. Number 1703751191	Unit Number F5153833	Date Commenced 9/4/11	
Consultant/G.P. Dr Caranagh	Prescribed By Named Nurse: Susan, Robbie Colleen		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 DISCONTINUED 21/5/11			

Evaluation/Review No	Date Due	Evaluation/Review No	Date Due
1	21/5/11 ✓	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 Leon Gratton Unit/CHI No 1703751191
F5153833

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>		9/4/11 →	→ Asymmer →

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:

Leon Gratton

Mental Health Nursing Service
 Care Plan [F1] - Jan 02
 Review by Jan 04

Date:

Record of Evaluation and / or Review

Signature

21511

① On general observations.

1700

② Settled on ward, though presenting as excitable and inappropriate comments towards staff at times.

③ 1:1 sessions with keyworkers continue.

④ Weekly multidisciplinary team ~~meetings~~ meetings to discuss client's mental and physical status.

⑤ Medication administered as per Kardex.

⑥ Good record keeping as per policy.

⑦ Liaising with Kingdom support workers and WFCOT re presenting problems.

Ref. nbc

Patients/Client Name **Leon Grathon**

Unit Number / CHI
F5153833 / 1103751191

Date of Birth **17/3/75**

Named Nurse/Key Worker **Susan, Robbie, Colleen, Isobel**

Date: Time:	Multi Disciplinary Record of Important Information not held in Evaluation/Review/Variation Records etc	Signature
9/4/11 1900	Informal admission of this 36 year old man. Brought in by WfCOT as planned admission due to deterioration in mental state caused by drug abuse. Over past few months (states before Christmas) has been "party'ing", taking speed^{AS} amphetamines (speed) 2g and 1g methadone. Has not been eating for past 6 weeks and reports weight loss of 2-3 stone. Leon wants to stop taking drugs but unable to find a solution to current situation. Therefore agreeable to admission. Spends £150-£265 per fortnight on drug use, has no money left to buy food with. Is currently in debt of £11,000 to banks. Leon has paranoia about death threats, being raped and murder. He states that people can read his mind and take thoughts out. No thought insertion. Reports a screaming female voice in the distance as though they are threats, also hears male voices issuing death threats. Reports only having about 1 hours sleep per night. Is on a depot flupenthixol 150mgs weekly last had 5/4/11, next due 12/4/11. A Miranda still to get note of regular medication from WfCOT. Leon has eczema and psoriasis, been prescribed betnovate for eczema and diprobaze. Betnovate to be applied first then diprobaze. Plan: General observation Escorted passes within hospital only Bloods, ECG, UDS Kardex Physical Renew Monday by A Caranagh Await call from WfCOT re medication.	ASymen
20/4/10	Leon has mainly been settled on the ward, although did require lorazepam 1mg at 1955hrs PRN for agitation/anxiety. Had good effect.	ASymen
23/10	UDS - +ve to Amphetamines. Nerd test +ve protein and trace blood. Sample to be obtained Monday morning.	EINAFad
10/4/11 0705	NIR Restless around the ward, requested night sedation. Dicky Docker prescribed Nihrazepam 10mg - same given as per Kardex. Late to settle but has slept well.	EINAFad
12/10	Settled on the ward once risen from bed. Ann Stanley WfCOT phoned re medication but as	

Patients/Client Name	Leon Gratton	Unit/CHI Number:	F5153833 1703751191
----------------------	--------------	------------------	------------------------

Date: Time:	Record of Important Information not held in Evaluation/Review/Variation etc	Signature
	Leon receives daily dispensing from GP they do not have current up to date medication list. Advised duty doctor who will pass on medical staff tomorrow 11/4/11 to phone Leon's GP. —	Aimee Graham
10/4/11 19:15hrs	Leon has appeared settled throughout shift.	
11/4/11 07:10	Settled within the ward. Requested & given 10mg Nitrazepam 10mg @ 22:15hrs with good effect. GP x once overnight for cigarette + hot drink	SP
1230	Settled morning spent around the ward	
	Feels settled Doctor w/ phone GP to get list of his medication. Was taking amphetamines & methadone. Has lost 2 to 3 stone in weight. Needs referral to dietician. feels less paranoid - still hearing voices. Depot due tomorrow - w/rot to clarify dose etc. Does not want passes yet thinks he will go home and take amphetamine.	M W/Ch
1700	Urine sample obtained for ward	
	Testing and 12:05 - clear for all.	Dr Wright
20:10	Received Lorazepam 1mg @ 18:35hrs. Settled in presentation @ time of writing — nil of note	People
12/4/11 07:15	NIR Bright and cheery with staff, referred to bed soon after accepting Nitrazepam 10mg, slept well overnight.	GENAFord
11.25	Diondon Leon referred due to reported weight loss of 2-3 stone prior to admission due to poor dietary intake secondary to alcohol & drug abuse. BMI remains within healthy range. Unable to speak with Leon as with keyworker. Written information left & have advised staff to contact if Leon wishes to discuss this with me	M MacDonald
15:25	Leon presenting as quiet, settled, seen by dietitian & support worker. Still to receive his depot today. Asleep @ time of writing	

Patients/Client Name

Leon Gatten

Unit/CHI Number: 5153833

1703751191.

Date: Time:	Record of Important Information not held in Evaluation/Review/Variation etc	Signature
15.25	- Depot confirmed 1/c L5 FLOT	
12.44	Clonazepam 10mg, clonazepam 10mg given 5/4/11 @ 12.44	(Papers)
19.10	Depot prescribed and given as per Kardex. Given 1mg clonazepam as per Kardex for anxiety/agitation.	Atkins
13/4/11	Rather unsettled overnight, rousing up all night. Has had Nitrozapam 5mg along with 10pm meds, has also approached staff on several occasions requesting as required during night. Has also approached staff at 23.55 also approached at 22.40, MARCOX 20mg at 00.55, and clonazepam 1mg 02.20, Has made little effort to get back to bed. Talking with friends on mobile phone at 02.00. Spending time between Daydream and Dementia.	Atkins
14.45	Generally settled using short passers. No concerns - Dr Meehan:- continue to assess.	Atkins
21.00	Settled, interacting with fellow clients. Good humour. NOTED throughout no concerns noted.	E. Atkins
14.4.11	Settled within the ward. Requested again 07.00 pm Nitrozapam 5mg along with regular 22.45hrs. Encouraged to return to bed at several occasions, did so at around 02.00hrs	Atkins
11.30	fairly settled morning. Complaining of sore feet. Medical staff still to look at them.	Atkins
20.00	Settled within ward. continues to walk around with untied laces despite staff advice.	Atkins
15.4.11	Awake all night despite requesting 10.35 requested Nitrozapam 10mg @ 21.40hrs. Constantly seeking out staff to either ask questions about various different things. Requesting 1mg clonazepam 1mg and prazosin 5mg @ 02.40hrs again with little effect. Also complaining that his feet are sore & cracked despite using a cream. Has requested to speak to the Dr at some point today. Would also like to discuss the possibility of an overnight pass.	Atkins
11.30	SR agreed for them to have an extended day pass and he has gone out with his support worker, going to do his washing and see some friends (due back for tea)	Atkins
19.00	Failed to return from pass at 17.00hrs contacted by telephone stated at a friends and missed bus will return at 4pm	Atkins

Patients/Client Name	Unit/CHI Number:
LEON GRATTON	5153833 1703751191

Date: Time:	Record of Important Information not held in Evaluation/Review/Variation etc	Signature
16-4-11 06-00	Leon had not returned to the ward by 22-00hrs. Mobile phone was engaged when I called him. Discussed with Duty Doctor and placed on overnight pass. At 02-45hrs, Leon phoned the ward and informed staff that he was at a party and would return to ward in the morning. He denied having consumed alcohol when asked. He was reminded that he had only been granted a day pass.	Pclerk
12-15	Remains on pass, tried contacting Leon again this morning but mobile just rang out.	EDuffin
19-30	Leon has still not returned from pass at time of writing.	Phyler
20-15	I attempted to contact Leon at 8pm "it was not possible to connect my call", so I have been unable to contact him.	MH Juby
16-4-11 21-30	AS Leon had not returned to ward by 21-00hrs, discussed with Duty Doctor and placed on overnight pass.	
23-30	Leon returned to ward at 23-30hrs. He informed staff that he had been at a party last night and had been asleep all day and mobile phone had run out of charge. He denied having taken alcohol or illicit drugs when asked. Asked to provide urine sample for drug screening which he agreed to but has yet to provide. Requested and given as required Mirtazapine 30mg at 01-00hrs. Appears to have slept for long periods overnight.	Pclerk
17-4-11	1-1 WITH LEON DISCUSSED RECENT PASS. LEON ADOPTED OF REASON FOR ADMISSION AND WAS AND TO ENGAGE WITH STAFF AS THIS BEHAVIOUR WAS INAPPROPRIATE. LEON STATED STATED HE WAS BORED AND WAS ADVISED TO SPEAK WITH CARE TEAM RE STRUCTURE OF DAY PASS, BY OT INPT.	Phyler
13/4/11 12-45	Leon has spent all morning in bed. Has not provided UOS as yet.	gHoban

Patients/Client Name

LEON CRAFTAN

Unit/CHI Number: F5153833
1703751191

Date: Time:	Record of Important Information not held in Evaluation/Review/Variation etc	Signature
19.00	Long periods in bed throughout afternoon. Accepted Fair diet. Fluids throughout obtained. Waking sample x2 shows positive to cannabis. Leon approached nursing staff asking for medication for "the blues". Given Sulfate. Cannabis still waiting on feedback from medical staff. Leon is aware of same.	E. Hines
18/4/11	(NR) Requested and given Lorazepam 1mg at 2200hrs for feeling agitated. Slept for long periods but when awake approached staff almost immediately requesting meds. On this occasion refused therefore returned to bed and appeared to sleep well.	H Mitchell
8.4.11	Leon has spent duration of the morning asleep in bed, remain there at time of reporting.	J.A. Gallagher
16.25		
3.4.11	DN Caravanah review verbal feedback Given from DN Nelson + physically improve weight increased + given final warning re drug use + placed on watch + no change to medication.	S. Hines
20.4.11	Settled, in good humour at times. PRN medication given Procydine 5mg 1828hrs. And paracetamol 1g 1910hrs	J. McPherson
19.4.11	Leon has not slept well overnight. Posing (N) no management problem but has approached staff at regular intervals for medication. Stating he is unable to settle and feels uptight. Administered Lorazepam 1mg as req @ 22.30 then a further Lorazepam 2mg @ 02.00. Advised Leon to attempt diaphragmatic relaxation exercises to manage anxiety. Slept from approx 5am onwards.	Fiona Gable
18.50	Settled morning. Diet given as per leaflet. No concerns	J. Hines
19.30	Settled evening around ward, time spent between dayroom and bed area. No other concerns to note.	E. Hines
19.4.11	Requested and given PRN Nitrazepam 5mg (07.00) at 23.45hrs. Late to settle, did not retire to bed until 02.00hrs. Appears to have slept well from this time.	NC Smith
12.30	DN Caravanah team meeting + to be discharged if under treatment. Influence of drugs/alcohol substances + physical state continues to improve + mental state stable at present.	

Patients/Client Name		Unit/CHI Number:
Leon Gratton		F 5153833 1703757191
Date: Time:	Record of Important Information not held in Evaluation/Review/Variation etc	Signature
20/11/11	Not deemed detainable at present	
1730	of passes as wishes, but to be discouraged from same	
	of key workers to speak with Leon to see if clarity if he has any debts	Simms
1230	settled presentation - proceeded on pass with Richmond Support Worker to cash his giro & go home for period of time	
	Due back around 1pm	Simms
1400	Belated entry from 19/11/11 a.m. Dr. Nelson will review Leon as complaining of neck pain and which he states has occurred. Since he did jujitsu and sustained a 'choke' to his neck, one year ago and experiencing pain in both ears, which he states he has had for many years.	
	Requesting to be weighed as worried regarding loss of weight, as he wants to gain weight so he can go back to the gym.	Almond
20/11	settled on the ward, interacting well with fellow patients,	Almond
21/11	NIR Vient to ATE to collect take away for another patient at the commencement of the shift.	
0700	On return continued to socialise with other patients. Awake majority of the night also requesting as required lorazepam which has been discontinued. Informed of this. Given as PRN nitrazepam 10mg at 2150 with no effect.	Almond
1230	settled morning. Short pass home to cash giro? UDS to be obtained, Leon well aware of same. Good diet and fluid intake, no change to plan of care	Edwards
1320	UDS confirmed as negative. Staff stood outside toilet whilst Leon supplied urine sample	Almond
20/11	Leon approached me to say another patient had a blade on him. Leon was upset by this as the gentleman hangs around with his ex girlfriend who he fathered a child to.	
	Otherwise Leon has socialised well and been settled.	Almond
22/11	Much more settled. Ordered a take-away meal from pizza house. Retired to bed shortly	

Patients/Client Name

LEON GRATTON.

Unit/CHI Number:

FS153853
1705751191.

Date: Time:	Record of Important Information not held in Evaluation/Review/Variation etc	Signature
	after 2300hrs = appears to have slept well	
22/4/10	Leon has appeared settled this morning	W.T.G.A.S./L
14:50	Settle pm spent socializing well with fellow clients within dayroom, no concerns at this time	Kubikra
23-4-10	N/K Slept poorly retired to bed by 00-30hrs.	
07:00	but awake and active around the ward again by 04-00 and remain awake at times of writing. Generally giggly and juvenile in presentation. Last night and staff have suspected that he may have been given medication (PRN) that was given to fellow patient.	
11:50	Leon has had a settled day today. No problems noted.	Amir
2035.	Leon appeared settled today. He was off the ward briefly to go shopping. Spending long periods in the company of fellow patients (GB).	W.T.G.A.S./L
24-4-11	Spent time in dayroom in company of fellow peers. Requested and given as required Nitrazepam 5mg along with as requested Nitrazepam 5mg + Prochlorperazine 5mg @ 22.00hrs with little effect. Poor sleep pattern continues overnight.	
24/4/11	Leon has been sleeping for long periods this morning.	
1235.	Accepted his manics medication without incident.	W.T.G.A.S./L
19:45	Leon has spent most of the afternoon and evening asleep in bed. Did attend dayroom at midday. No concerns.	M.H. Tahir
25/4/11	N/K Woke at 23 ⁴⁵ hrs. Fairly quiet. Requested and given as required Nitrazepam 10mg and Prochlorperazine 5mg at 23 ⁵⁵ . Returned to bed around 00:30 and has slept soundly overnight.	ENAFARI
06:30	Time spent mostly in bed this morning.	SHS
26-4-11	little sleep gained overnight despite receiving pm Nitrazepam 5mg @ 00.30hrs on top of regular night sedation. No management problem overnight.	
10pm.	Awake early, presenting as settled + placid on pass home, returned at lunch time.	SHS
1pm	Depart due to day	SHS
1950	Settled on the ward, interacting with fellow patients.	Amir

Patients/Client Name

Leon Gratton

Unit/CHI Number: F5153833

Date: Time:	Record of Important Information not held in Evaluation/Review/Variation etc	Signature
26/4/11 2000	Depot administered today on (R) side, next due 3/5/11.	RAM nbg
26/4/11 0640	Settled evening, spending time in company of peers. Retired and appears to have slept well.	JAL
1200	Settled, off ward with support worker. No concerns.	ALH
1950	Leon has appeared settled. He was given Procyclidine 5mg, as required medication at 1815 for a tremor in both hands.	W. J. A. S. / J.
28/4/11 0655	Remained settled. Requested as required Nitrazepam 5mg @ 22.40hrs. Slept for long periods overnight.	J.
1215	Spent all morning in bed until visit and support worker from Richmond and Fiona Hunter in to see him at 1130hrs, only feedback from meeting was Richmond continuing and to advise visit of discharge date.	Almes
2025	Settled all afternoon, requested and given procyclidine 5mg at 1830 hours.	RAM nbg
28/4/11 0655	Settled evening spent socialising with fellow clients, wishes to have medication review, as would like something stronger than Procyclidine. Retired and slept well.	J. AL
1200	Leon presenting as generally settled. Visited by support worker. No complaints.	J. AL
29/4/11 2045	Generally settled throughout the P.M. no concerns. Procyclidine 5mg given as required per drug kardex.	J. AL
30/4/11 (0645)	Settled initially however became increasingly agitated. Requested and given P.M. Haloperidol 5mg given at 23.55hrs. Requested to speak with staff, appeared weepy and upset, thinking about his childhood. Stated he never had a great upbringing by his mother and that she used to knock his confidence at any opportunity. He also spoke about how upset he is about having his child given up for adoption. He would also like to move home, as he feels if he goes back home, he will more than likely take drugs again. I did reiterate that it is his responsibility & choice to keep himself safe. Leon thanked me for listening to him and allowing him to ventilate his	J. AL

Patients/Client Name

Leon Grotton

Unit/CHI Number:

F5153833

Date: Time:	Record of Important Information not held in Evaluation/Review/Variation etc	Signature
cont 20/4/11	thoughts and feelings. Spent time following us resting, spending time within the dayroom in the company of fellow patient. Appeared to have had a good settling effect from PRN Haloperidol 5mgs he received earlier, albeit Leon did not retire to bed until 04:00hrs. Appears to have slept soundly from this time, remains so at time of writing.	MC Smith
12:30	Belated entry from 29/4/11. Feedback from Dr. Cavanagh - Presents as mentally stable. Improvement in physical health. Continue with regime. Passed as wished.	
	Leon has spoken with his support worker recently regarding applying for change of home, as present area/accommodation means it's difficult for him to stay off drugs.	
19:50	Long periods within bed area this a.m. Leon has remained in bed most of the day, settled when up and complaining of over sleeping but would not stay up.	A Graham
20/4/11 1.5.11 NR 06:10	Have to settle in bed; requested and given prn procyclidine 5mg at 23:45hrs for restlessness. Has sleep for the latter part of the night.	MC Smith
20/4/11 8:15pm	Has spent most of morning in bed area, settled in presentation. Leon has presented as settled, irritable short periods of word irritable appropriately. Day worker unable to meet with Leon as planned due to busy ward environment.	MC Smith
21/5/11 (6:45)	PRN Nitrazepam 10mgs given at 21:45hrs and also requested and given Maalox 90 heartburn. Has not slept at all overnight, spent most of the evening within the dayroom.	MC Smith
13:40	UDS to be obtained. Leon bright in presentation this morning.	MC Smith
19:45	Leon has been sleeping most of the shift. Still to provide sample for UDS. Staff to keep reminding him.	MC Smith

Patients/Client Name Leon Gratton	Unit/CHI Number: F5153833.
--------------------------------------	-------------------------------

Date: Time:	Record of Important Information not held in Evaluation/Review/Variation etc	Signature
2/5/11 (07.10)	In bed sleeping at the start of the night, as a result witheld 10pm medication. Woke at 01.45hrs, requested and given Procydiline 5mgs at 02.10hrs as Leon complaining of tremor and teeth grinding. Returned back to bed at 03.10hrs. Slept again thereafter. No urine sample gained yet for UDS. Remains sleeping at time of writing.	MC Smith
1155	Leon has been up this morning and off the ward with his support worker, bright in mood and sociable.	W. T. T. T.
2010	Requested and given as required procydiline 5mg at 14.10hrs as stating jaw sore and grinding teeth. Requested more with pain meds but declined as not within 8 hour limit. Requested maalox for indigestion. Given same 20mls at 1955hrs.	Allyne R. M. V. C.
2130	Depot administered today. UDS negative.	
4/5/11	(NB) Depot forwarded in the diary. Slept very little overnight has tried but no success. Reprimanded for being loud when fellow patients attempting to sleep. Appearing quite elated at start of shift, keen for staff to read his book of poems!!! % feeling tremulous given procydiline at 22.35. Maalox 10mls given for upset stomach at 03.15hrs. Has spent all night awake and in the dayroom.	W. T. T. T.
1530	Dr Cavanagh meeting Leon's procydiline medication was changed to ophenadine as staff were aware that Leon may be getting a slight buzz from procydiline. Dr Cavanagh requested that a supervised urine sample be taken for used UDS testing. Staff asked Leon but Leon was unable to produce at this time.	Chin
1530	Leon has had a settled day today. Bright in mood and accepting of medication changes.	W. T. T. T.
2000	URINE SAMPLE OBTAINED THIS AFTERNOON SHOWS NEGATIVE TO ALL RESULTS (UAS) LEON HAS PRESENTED (HAPPILY) SETTLED THROUGHOUT. NURSING STAFF NOTED ON TWO OCCASIONS LEON WAS LAUGHING AND RESPONDING WELL ON HIS OWN IN BED AREA. VISITED BY SUPPORT WORKER TIME OFF WORK NO LACERATION NOTED F. T. T. T.	

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

Page No...!!..

Patients/Client Name

Unit/CHI Number:

LEON GRATTON.

F51 53833

Date: Time:	Record of Important Information not held in Evaluation/Review/Variation etc	Signature
5.5.11	Elated in presentation at the beginning of the night.	
06.45	Noted to be following staff members around and requesting various different things from medication to food. Did not settle into bed until 01.30hrs however has slept well from this time.	ARBO & Co.
14.00	Leon went out home this morning, due to return later this afternoon.	
5/5/11	1:1 session with Leon this evening. He appeared bright in mood during interview. Asked Leon what he thought he had benefited from his current stay in Ward 2 - reported that his mental state had improved because he had stayed away from drugs. Said he would have found it hard to stay away from drugs if he had not been admitted. Reported that he wishes to stay away from his present residence and to find new housing away from drug dealers. Would like to stay on ward longer, but understands that he can not stay for long period. He thinks that he has received a housing form at home and would like help to fill it in. Denied owing anyone drug money although he was hesitant when he answered the question. Leon stated that he was experiencing some dizzy spells for about 48 hours which he thinks is being caused by ophradrine. Advised him that staff will continue to monitor. When asked why he appeared to be high/elated - he reported that he is not afraid to laugh like other clients. Not app ^{er} Reported that he is not experiencing any auditory hallucinations and and/or distressing thought. Leon has been settled this pm, no concerns noted.	ARBO & Co.
6/5/11	In good spirit at the commencement of shift eating table ^{ts} away in the day	ARBO & Co.

Patients/Client Name

LEON GRATTON

Unit/CHI Number:

F5155 J33

Date: Time:	Record of Important Information not held in Evaluation/Review/Variation etc	Signature
6/5/11	Slept for short periods. Approached N/R staff for feeling anxious at the time. Given re-assurance. Up early from 5am spending time between day-room and bed space.	ASDERS
12:45	Out with support worker this morning. Hair cut and facial hair trimmed. Settled whilst on ward.	ABYNE
7:30pm	Requested & given Orphenadrine 50mg at 18:00hrs for EPS's. Generally settled in presentation at times. Tone of voice loud & rattles, swaggy like gait evident.	SIMMS
7/5/11	Leon presenting as settled & sociable with other patients.	
06:15	retired to bed early and appeared to sleep well overnight.	AMASIA
11:15/11	Did not attend for 8am medications despite social prompts from staff. Remains in bed at time of writing.	J. HOBAN
7:50pm	Refused 6pm diprivate cream. Settled in presentation. Socialising well with fellow clients.	SIMMS
8.5.11	Spent time in dayroom socialising with fellow clients. Requested & given as required Orphenadrine @ 21:50hrs. Slept for short periods overnight.	J
06:15	LEON REFUSED TO RISE FOR 8AM MEDICATION TODAY. OTHERWISE SETTLED.	Abb
12:15	Spent time in dayroom and courtyard. Requested and given as required orphenadrine 50mg at 16:45hr for side effects of depot which had good settling effect. No other concerns to report.	ENAGLEY
9.5.11	Slept for long periods overnight, offered 06:30 no complaints.	THALL
1pm	Refused to rise for 8am medication, nurse administered 8am medication.	
	Dr. Lavanagh: patient review	
	+ Spending most of his time asleep	
	+ Sleeping well at night, but also throughout days	
	+ Looks physically better since admission.	
	+ mental state improving/improved.	
	+ Has not spent time in house yet, no plans to make changes	
	+ Wants to change relationship with drugs	

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

Patients/Client Name

Page No 13...

Leon Gratton

Unit/CHI Number
146375191
TJ 153833

Date: Time:	Multi Disciplinary Record of Important Information not held in Evaluation/Review/Variation Records etc	Signature
9/11/11 1800	* NOT seen son, he visits mother → NO relationship with mum. Plan to spend time at home including 1 x overnight pass this week. * Try to structure day: get up 10am. Shower + dress, housework, collect medication. * Richmond visit 3 x weekly * Social group also browse drugs → Leon advised to stay clear from this	
20-00	Settled, using Passes only. The ward with no concerns to report accepted Fair Diet/Fruits. Requested and given 10mg Nitrazepam at 19:40. Settling good. Humour noted.	S. D. M.
09/10/11 0800	10mg and ORPHENADRINE 50mg at 21:30, retired around 01:30, and appears to have slept well.	Alymer E. A. M.
10/5/11 1240	Leon refused his 0800 medication. On rising to his medication, ordered.	J. C.
1425	Leon was given his depot, flupenthixol decanoate 150mg as per Kardex on his ① hand side.	L. T. W.
1900	Requested madox as required after evening meal. Given same 20mg at 18:25hrs. Later Leon approached staff advising a male patient made as if to kick him when crowded down waiting on meds outside treatment room. No contact made, but action intimidated Leon. Admitted not to wish to make self vulnerable/easy target.	L. T. W. / S. D. M.
11/5/11 0900	Slept very little overnight. Requested as required - Orphenadrine 50mg @ 02:05 + then again 03:25hrs as he was experiencing side effect from depot.	Alymer
1430	* At Caranagh team meeting! * Nitrazepam at night now increased to 20mg to see if it will help Leon sleep at night. * If this does not help melatonin will be considered. * To say to Leon to go out on a weekend pass for 2 nights from Fri-Sun. Pass meds to be ordered. * Infection will visit Leon during above pass.	
1435	Leon has been settled this morning. Escorted by Richmond Support worker to visit home. She stated Leon is the lowest he's ever been.	Alymer Alymer A. G. R.

Patients/Client Name

LEON GRATTON

Unit/CHI Number:

F 5153833 / 1703751191

Date: Time:	Multi Disciplinary Record of Important Information not held in Evaluation/Review/Variation Records etc	Signature
11/5/11 2015	Leon has appeared settled. He approached staff stating he has heart burn/indigestion. He was given 20mls Mucloxa as required medication, as per Kardex.	W. Tybalt sp
12.05.11 0700	Quiet evening, retired after 10pm medication, and appears to have slept well.	JW
12/5/11 1200	Refused to have a 1:1 session with his Keyworker today. Has spent all morning sleeping.	Estimote
12/5/11 1950	Unit staff & ward staff for patient having a 1:1 session. Leon reasonably settled, spending long periods on top of bed. Had 1:1 sessions with staff to discuss weekend passes.	F. Hume Sp/STH
13.5.11 06:35	Leon has been up & down overnight. Orphenadrine 50mg for shakes x2 overnight.	Patroll
13/5/11 1315	Leon has appeared 'silly' and childish in manner at times. No concerns.	W. Tybalt sp
2100	Generally settled. Awaiting urine sample for UDS.	JW
13.05.11 0643	Fairly settled evening, requested and given as required orphenadrine 50mg at 2300. Retired around 0130, and appears to have slept well.	JW
1145	Refused morning medication. Has spent the morning in bed. Ged Caughlin WFOOT attended ward, Leon is due to get paid on 18/5/11 and will arrange with Richmond to pay his gas, electric bills and buy food. Has paranoid thoughts regarding people being after him. Encouraged to get up and have a shower.	Abraham
14.45	Settled afternoon/evening around ward. Socialising with fellow patients. No other concerns to note.	ER Duffly
14.5.11 012	Leon has not slept overnight. Spent time reading or watching his DVD player. Requested and given pm orphenadrine 50mg at 2130. Continues to be troubled by shaking/tremor; concerned that it is not being taken seriously. Advised to discuss this again with medical staff.	KA Remen
15/5/11 1100	Leon has been evident around ward this morning. Spending time in day room. UDS negative to all.	gitter
12.00	Approached staff complaining of chest pain on L side of breast plate. Duty Doctor contacted via MHAT and vital observations taken Temp 35.4°C, BP 112/76, P70, O2 Sats 98%, resp 32.	

Patients/Client Name

Leon Gratten

Unit/CHI Number:

FS153833/1703751191

Date:
Time:

Multi Disciplinary Record of Important Information not held in Evaluation/Review/Variation Records etc

Signature

Cont Anticipating contact from Duty Dr Muir at time of writing

15¹⁵ Leon spoke to myself, Complained of experiencing continued chest pain - Sore, Sharp pain under left breast, Central pain + middle of back pain. States not sore when breathes in or out. Coughing green brown white phlegm. Describes neck sore for weeks. Has pain in both sides of ribs for weeks

E. Duff

Stated he has experienced chest pain loads of times, which G.P. told him was due to anxiety. Doesn't feel anxious, feels his hands tremble alot when he's relaxed. Smokes 40 cigarettes a day which he attributes to being wheezy. Slight wheeziness evidenced. Vital observations - B/P 116/69 P 63 T. 36.1°C O₂Sats - 99%

1940 Leon Mearns, M.H.S. contacted still awaiting duty dr to attend ward. Requested orphenadine 50mg for pain. Given same as leg shaking and stated hand trembling, same as same. Given orphenadine 50mg at 1945hrs. Requested as required maalox, states needs it at 1935hrs. Given 10mls maalox

Abraham

16-5-11 Duty doctor attended ward and met with Leon. In discussion, Leon stated that he has experienced these pains in his chest since he was 18 and has attended GP several times due to this. No new pain experienced. All physical examinations normal with some tenderness between ribs.

Alymer

Analgesia changed to ~~co-codamol~~ as per Kardex.

06:30h Leon was given ~~per~~ co-codamol 8/500 x 2 as per Kardex. Retired to bed 23.00hrs and has slept well overnight.

M. Gage

13:10h Leon awake for 8am medication; returned back to bed. Remained in bed until reviewed by medical staff

A. B. L. H.

13:30h Dr Lowman patient review taken by Dr Subbarayan + Dr Nelson. Complaints of chest pain yesterday; advised Dr Nelson that doctor last evening advised pain due to his rib muscles being swollen. Advised medical staff he's doing fine &

Stamps

Patients/Client Name

Unit/CHI Number:

Leon Crichton

F5153833/17275/19

Date: Time:	Multi Disciplinary Record of Important Information not held in Evaluation/Review/Variation Records etc	Signature
16/5/11 1330	coping fine. * Spoke of his neighbour coming to see him yesterday. as was worried about him as thought he had "been killed + got rid of". * spoke of friends who used drugs making playing practical jokes on him prior to admission. * spoke of experiencing "Voices" outside his head. Advised staff that he was answering them back. → challenged returning his shift. Staff did not report this to morning staff. Stated he ignores these voices. * Stated he's having acid flashbacks which causing his rib pain + arm pain. * Advised that he's hopeful he will be ready for discharge soon. * Agreed to perm his wrist. as get benefits paid to enable him to buy food + electric. * Perm → Day passes + overnight perm Tuesday → Friday. W/ out x 2 staff to be asked to possibly visit whilst Leon on perm. * Denied any recent drug use. * to be assessed if wishing to leave.	
2035	Settled evening. No concerns.	Sum...
15/11 06:25	Settled in presentation, bright and sociable. Slept for short periods.	SHS NC
17.5.11 10.55	Evident around the ward at start of duty presenting as bright and conversant. of neck pain still to receive pain relief as yet as awaiting delivery from pharmacy. Leon to be currently on short perm to home to collect mail accompanied by staff member from Kingdom Housing. due to return to the ward 12 noon.	Sm...
1135	Settled, not given co-codamol 8/500 this morning as no stock. Went home with support worker.	SHS CC
1530	Depot given right side, next one due at next Tuesday.	
830pm	Settled presentation, mood + mental state	

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

Page No. 17

Patients/Client Name

Unit/CHI Number:

Leon Graham

T5153833
1703751141

Date: Time:	Record of Important Information not held in Evaluation/Review/Variation etc	Signature
17/5/11 8:30pm	appears stable NOT observed to be responding to any auditory or visual hallucinations. Given firm bandages not to using a fellow	
18/5/11 06:50	male wheelchair on 2 occasions - Slept little overnight. Somewhat inappropriately in conversation with staff. Mixed with fellow patients	Stirling
1315	team meeting: * Discharge date set for 23/5/11, to advise Leon. * If tomorrow's overnight pass goes well to go out on pass at weekend to return on Monday to be discharged. * Wknot aware of tomorrow's pass and will arrange to visit Leon at home	hnd
1320	Leon was spent periods in bed this morning. Rose for lunch, refused 8am medication.	Allyne
1940	Leon settled in presentation. Given as requested orphenadrine 50mg for tremor.	Allyne
19/5/11 0625	NIR Mood bright socialising well with fellow-patient and staff. Up for long spell in company of others. Requested and given orphenadrine 50mg 0200 at slept for short time. No concerns this morning.	Allyne
1145	Settled, willing to go on pass, medication ordered.	Bardas
1530	Retrospective Entry. 1:1 with Leon on 18/5/11, spoke about drugs and Leon denied having used any drugs recently. Also denies owing anyone money for drugs. Asked Michael why he had been reluctant to go on pass when he got his benefits last week and he did not have an explanation for same. He will however go on pass from 19/5/11 to 20/5/11. Leon was not happy that his Kingdom support workers had failed to show up to take him out. He however went out on his own.	Allyne
20-5/11 0700	Phone call from Leon last night requesting that his pers meds be ready for 1800hrs tonight as he would be seeing his son + taking him out to the pictures. Also he wouldn't have time to	Allyne

Patients/Client Name

LEON GRATTON

Unit/CHI Number:

ES153 PSS
CHI 1703751191

Date: Time:	Record of Important Information not held in Evaluation/Review/Variation etc	Signature
20/5/11	Speak to the Dr's. Leon also said that he'd	
06 ¹⁰	He taking discharge on Monday	
20/5/11	Leon had not returned from pass. S/N Wright phoned Leon	
2015	who stated he would be back in an hour or so after he	
	had had a shower.	
1355	Telephone call from Cathy Hilditch (WFCOT). They	
	have been out to Leon's house, the house	
	is disgusting with glasses, empty cans and	
	cigarette butts everywhere strewn all	
	over the floor - also clothes everywhere.	
	High energy cans in evidence - all suggestive	
	of a party before he came in or recently.	
	Despite this he reports eating and sleeping	
	OK, shopping for food OK. He plans to	
	come up for his medication this afternoon	
	and for discharge on Monday.	
	Please request a urine drug screen when he	
	returns to the ward this afternoon.	
21/5/11	Leon returned from pass at 1900 hrs to pick	
2000	up medication for a further overnight	
	pass. On being questioned by staff he	
	admitted reported that he had taken	
	cocaine and amphetamines at home	
	on Thursday night. Said he had taken	
	same because he was bored, Leon was	
	appropriate in manner and did not	
	appear intoxicated when he attended	
	the ward. Proceeded on pass until	
	9pm on Sunday. Pass medication	
	issued.	
8000	Leon returned from pass this evening, settled	
	in presentation, bright and sociable (6 presentation)	
23511	Remained settled retired to bed @	
06 ¹⁰	around midnight. T appears to have slept	
	well	
1530	Dr. Subharayan Meeting.	
	• took speed and cocaine on pass, regrets same.	
	PLAN	
	• discharge home tomorrow.	
	• discharge script done, to be followed	
	up by WFCOT.	
	Spent all morning in bed.	

Patients/Client Name

Unit/CHI Number:

Leon Gration

FS 53833 / 1703751191

[illegible]

Observation Care Plan - GENERAL

Patient's Name Leon Gratton DOB 17/3/75 CHI/Unit No. FS153833

Ward 2 Responsible Consultant Dr Cavange

Physical Description

Height	<u>1.86</u>	Hair	<u>Brown</u>
Weight	<u>70kg</u>	Build	<u>Medium</u>
Eye Colour	<u>Blue</u>	Dist. Features	

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

To assess mood & mental state

Specific interactions and limits to be applied

Passes unescorted within including co-op

Prescribing Nurse Signature [Signature] Grade S/N Date 8/4/11

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

This Care Plan has been discussed and agreed (Patient signature) Date

Nursing Signature Date

Medical Signature Date

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

[illegible]

Ward /Dept

2

Name: Leon Gratten		Care Plan Number 1	
C.H.I. Number 170375491	Unit Number F5153855	Date Commenced 8/9/11	
Consultant/G.P. Dr Lavanagh	Prescribed By Named Nurse: [Signature]	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	19/11/11 ✓	6	
2	19/12/11	7	
3		8	
4		9	
5		10	

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

Patient/Client Name Leon Craffon Unit/CHI No 1703751191
P5153855

ACTION TO BE TAKEN: -

CARE PLAN - Admission to Acute Ward

Date

Signature

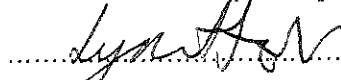
1. Implement observation level as prescribed by multidisciplinary team in accordance with Trust /hospital policy and procedure.
2. Observe client's behaviour, social interactions and participation in activities.
3. One to one patient interactions enable collection of information on the client's mental 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. *Individual Nursing Actions Required: -*

8/9/11



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:



Fife Primary Care NHS Trust - Mental Health Directorate
Care Plan [0]



Ward /Dept TWO

Name: <u>LEON GRATTON</u>		Care Plan Number 2	
C.H.I. Number <u>1703751191</u>	Unit Number <u>F5153855</u>	Date Commenced <u>19/11/11</u>	
Consultant/G.P. <u>DR CAVANAGH</u>	Prescribed By Named Nurse: <u>LIZ, JEAN & ISABEL</u>	Date Resolved	
Description of Need: Leon's ABL processing and motor skills fall beneath both skill and age expectation combined with motivational issues. Neglects personal care and has difficulties structuring^{ed} structuring his days			
Objective/Expected Outcome Provide encouragement/support with ABL'S and promote motivation by encouraging participation in activities.			
Actual Outcome			
Evaluation/Review No	Date Due	Evaluation/Review No	Date Due
1	19/12/11	6	
2		7	
3		8	
4		9	
5		10	

Fife Primary Care NHS Trust - Mental Health Directorate
Care Plan [0]

Patient/Client Name Leon Gratton

Unit/CHI No 1703751191

ACTION TO BE TAKEN:-

- Encourage Leon to rise in the morning and either shower/wash.
- Encourage Leon providing guidance to tidy bed area and look after belongings by separating clean/dirty clothing.
- Refer Leon to O/T for assessment & inclusion in activity.
- Meet with Leon to complete regular weekly planner to structure days.
- Continue to monitor above

Date

Signature

↑
11/11/11
↓

↑
A. Duff
↓

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 plan of care explained to me and I do/do not wish this to be initiated:

Patients/Client Name: LEAN GRATTON

Unit / CHI No. 1703751191

Named Nurse/Key worker

LIZ, JEAN & JOSEPH

Care Plan No

2

Date:

Record of Evaluation and / or Review

Signature

Time:

19/11/11	Continual prompting with personal care, although rarely attends to same - advised that foot odour is evident and that is unpleasant to others who share bed area. Referred to O/T department for assessment
----------	---

Erdfly

NHS Fife – Mental Health
ADMISSION ASSESSMENT / HISTORY TAKING [A1-1b Elderly]



Patients Name Leon Gration

Unit/CHI No F5153833
1703751191

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)

Referred by WFCOT, due to concerns of deteriorating mental state, vulnerability, poor dietary intake, loss of weight

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)

Agreeing to being in hospital, trying to get out of drug life. Being intimidated by drug dealers.

10 Nursing observation of patient physical state

Temperature 36.3 Pulse 115 Blood Pressure 117/76
Urinalysis N/A Skin State Intact Glasses N/A Hearing Aid N/A
Dentures N/A Dentures Marked: Yes ☐ No ☐

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

General Appearance Casually Dressed
Distinguishing features _____
Height 1.86m Weight 70kg Build medium Eye Colour Blue
Hair colour _____ Shoe Size _____ Posture _____

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)

No physical problems reported

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)

Reduced self care when at home

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)

No problems reported

15 Confusion problems experienced at home/previous care setting

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

No problems reported

NHS Fife – Mental Health
ADMISSION ASSESSMENT / HISTORY TAKING [A1-1b Elderly]

Patients Name Leon Graham Unit No FS153833
1703751191

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)

none reported

17 Other experienced at home/previous care setting
(as expressed by main carer/other relatives or staff)

none reported

18 Emotional problems experienced at home/previous care setting

none reported

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

Well known to services, previous admission to ward 2. Current admission due to deterioration in mental state, Deterioration in social situation, also vulnerable continued intimidation from drug dealers.

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

Previous admissions to ward 2

To be completed within 48 - 72 hrs of admission



Patients Name Leon Gratton

Unit/Chi No PS153833
1703751191

[1] Memory/orientation needs:

Query problems with short-term memory, however long term memory appears intact. Nil Problems reported. Orientated to time place and person.

[2] Behaviour needs: [Mental State]

Not noted to be responding to unknown stimuli, occasionally reports auditory hallucinations to staff, however no behaviour witnessed or distress noted that supports these claims. Can be intrusive and over familiar especially with Female staff and peers.

[3] Communication needs: [Social interaction]

Nil problems noted or reported. Good level of social interaction shown on ward.

[4] Mood disturbance needs: [Mental State]

Leon's account is that he has been having Flashbacks, visual and auditory hallucinations. Currently bright in mood with none of the above visibly disturbing his affective state. Staff continue to monitor.

[5] Sleep needs: Sleeping well since admission - Leon's account is that he is sleeping to much.

[6] Continence needs [Toileting]

Nil problems noted or reported in regards to this area of functioning.

[7] Washing/dressing needs [Self care] Leon is capable of attending to his personal care needs. However from a previous O/T assessment Leon's ADL processing falls beneath both skill and age expectation combined with motivational issues. Reluctant to attend to above despite regular prompting.

[8] Nutrition/weight needs, including Personal likes (sugar in tea/coffee etc). Significant weight loss on admission as spending all monies illicit substances and was eating out of local baker's bins. Good dietary intake since admission, plus takeaway food on occasion. Weight reviewed weekly.

FS153833
17.03.11 (9)Patients Name Leon Gatten

Unit/CHI No

[9] Mobility needs

Nil problems, mobilising independently.

[10] Skin/pressure care needs

Nil problems, skin intact. Query - reports suffers from Eczema

[11] Physical health/pain needs

Complaining of somatic symptoms. Examined by medical staff no physical cause evident. Requesting regular pain relief (paracetamol & ibuprofen)

[12] Medication

As per Kardex

[13] Social/family needs [House care/Community living]

Lives alone in appalling conditions. Has leaking sewage pipe external to his accommodation. Clearly not coping in community. Mother is supportive, but suffers from physical illness at present.

[14] Community Services

Poor compliance with outpatient appointments. Engages well with community outreach team but is visited by x2 staff due to over familiarity with female staff. Also has social work involvement.

[15] Financial/clothing needs

Mother collects benefits and supplies Leon with money whilst an inpatient.

Emotional / Psychological needs:

Requires on-going support and reassurance.

Is Patient / Client in receipt of pension book:

Yes ☐No ☒

Specify _____

Who holds Pension Book MOTHERWho holds house keys MOTHERSignature: Elizabeth D. S.N.

Patients/Client Name

Leon Gratton

Unit Number / CHI

FS153833 / 1703751191

Date of Birth

17/03/75

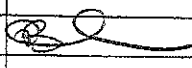
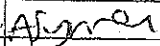
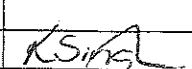
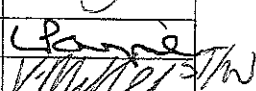
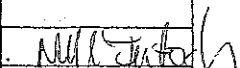
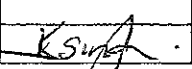
Named Nurse/Key Worker

Date: Time:	Multi Disciplinary Record of Important Information not held in Evaluation/Review/Variation Records etc	Signature
8/9/11 1800	Leon admitted today through WSCOT due to deterioration in mental state while awaiting rehab. He was seen by Dr Cavanagh yesterday regarding same. WSCOT staff report since discharge Leon's lifestyle has become more chaotic, using amphetamines ecstasy and cocaine on regular basis. Leon admits drug habit had been worse but denies any drug use over last 2 weeks. Denies any alcohol use for week, denies IV drug use. He reported social situation worsening, lives alone not been eating due to no money, all on drugs. Remains intimidated by drug dealers but has paid all his debts as not taken anything for two weeks. Leon states he has been brought in as 'not coping', poor concentration 'not low in mood' just angry. Denies suicidal ideation. Admits to feeling 'angry + irritable' he denies any current visual or auditory hallucination, says only happens when on drugs however from Dr Cavanagh's assessment yesterday he appeared to have thought disorder and was having hallucinations. Urine drug screen on ward negative to all. Plan - Informal admission as per Dr Cavanagh, vulnerable deterioration in mental state. Deteriorating social situation - UDS on ward done = Negative to all - Kardex - Physical done no concerns - Bloods done - Confined to ward currently (escorted passes in hospital with staff if pushes only) - General observations - To be reviewed by Dr Cavana more	
2107 9-9-11 0630	Leon has presented as settled, no concerns settled around ward, ordered takeaway, retired to bed early appeared to sleep well.	
14.45	Leon slept until around 12pm. Has been settled, spending time around the ward since rising.	

Patients/Client Name	Unit/CHI Number:
Leon Gration	T-5157833 1703751191

Date: Time:	Record of Important Information not held in Evaluation/Review/Variation etc	Signature
09:00	Information passed over from Dr. Cavanagh	
09:30	2 Dr. Cavanagh	
	Leon not cleaned adequately at present but staff to encourage Leon to stay on ward.	
20:50	Settled - no concerns to note	J. McPherson
09:11 (NR)	Generally settled, socialising with other patients. Late to retire to bed but has slept well since around 03:00hrs.	R. Sings
12:45	Leon arrived early, does not appear to have attended to personal care needs. Humour pleasant & appropriate in manner. Conversation. Socialising with others. Mood appears euthymic.	S. Sings
19:50	Leon	
11:00	Leon was late to settle. No problems noted. Appears to have slept well since.	R. Sings
12:20	Leon has remained in bed all shift.	R. Sings
20:00	Leon requested a L.I. this evening. I met with him and he spoke about his Mum having a breathing condition - she can hardly breathe - stated it was rare and she may only have 4 years to live. - appeared quite upset by this. Leon went on to talk about satanic rituals, witchcraft and snuff movies - he was difficult to follow during this. Spoke about hearing voices when at home but not here.	R. Sings
12:09:11	Leon was sleeping in the music room at the start of the shift. Rose feeling hungry, given juice & biscuits, settled and slept again.	R. Sings
12:15	DR. CAVANAGH'S MEETING: No change, to discuss plan of care tomorrow. Leon has been settled, but asking for time off the ward. Advised to discuss passes with Dr. Cavanagh tomorrow.	R. Sings
14:10	Leon approached staff saying he was feeling dizzy. Vital obs done. Pulse 79 BP 116/66 and temp 35.7. Bm performed 4.6. Dr. O'Neil contacted, not concerned. Contact later if concerned.	R. Sings

Patients/Client Name	Unit/CHI Number:
Leon Griffin	F 5153883 170375/191

Date: Time:	Record of Important Information not held in Evaluation/Review/Variation etc	Signature
20:00	Satellied around the ward this afternoon, visited by his mother, No concerns reported	
20:25	Frequently seeking out staff to converse. At times requested to move when staff writing in nursing notes.	
13-9-11 (NR)	Continued to seek out staff to converse with:	
06:40	Spoke to myself about concerns about going to rehab. Anxious that his benefits will be cut. Spoke about past events in his life leading up to his drug taking. Slept for long spells overnight.	
11:55	Satellied morning. Did not receive same medication as was to sleep. Has appeared bright in mood since rising.	
20:15	101 With Leon this evening at his request, reports feeling rubbish and fed up since coming in. He spoke about believing his mother has her breathing problems due to this cover (cuisse) in Walter Hailes - states that if they are responsible then he will find out. Also went on to talk about not feeling very well and feeling dizzy (B.P is low) at present and advised to drink fluids without caffeine at present. Leon went on to chat about various other things - having a broken heart leads to diabetes and then death, his relationship with V. Black and how she treated him. Leon was talking about other clients which encouraged him not to do. After 11 Leon later has been slightly inappropriate - calling staff arrogant and other staff requesting to go home with them.	
14-9-11 (NR)	Requested razor to shave of beard.	
06:15	Some given but when Leon handed staff back razor he had not shaved beard. Later approached myself saying that he had cut leg and ankle with razor. Two cuts evident but superficial, clean and dry requiring no treatment. Retired to bed around 23:30hrs and has slept well overnight.	

Patients/Client Name

Leon Gration

Unit/CHI Number: F553833

1703751191

Date: Time:	Record of Important Information not held in Evaluation/Review/Variation etc	Signature
0635	(12) Given as required Lorazepam 1mg at 22.05 hrs with good effect.	K Singh
1305	Settled morning - up early this morning. DR. Cantan's team meeting:- - No passes @ present - Awaiting Rehab	Chapman
14/9/11 2045	Settled pm, long periods spent in corridor interacting with staff and peers. Reported that he has boils under arm. Has been using hot compress on them.	RA - mby
15/9/11 0630	Paul Percival 1g for headache at 2215, in bed settled and slept well overnight.	MSW
1140	Leon required encouragement to rise for 8am medication. Leon has spent lengthy spells sleeping in bed or within day room.	Simon
2000	Leon requesting 1:1 session - Leon discussed his fears over his mother dying - he states she has 4 years to live - Discussed how his mother will never meet his baby, who was born last year - Spoke about abuse (sexual) that he suffered when younger - States he told ex-partner about this - which he feels was a mistake - feels he may have been given drug - 98H and raped - Has nightmares about this - worried about taking drugs due to recent local deaths - Spoke about wanting to go to rehab and get a new house Given support and reassurance and time to vent feelings.	
15/16.9.11 1700	Leon asked to meet with myself c/w Hutchinson. He voiced his concern about another patient who is due to be discharged tomorrow. Leon said he saw this man turn from purple to blue and he had had to take his pulse on six points of the wrist as per the Chinese way and stated that all nurses/medical staff should	Sthe

Patients/Client Name LEON GRATION	Unit/CHI Number: P5153855 CHI 1703751191
---	--

Date: Time:	Record of Important Information not held in Evaluation/Review/Variation etc	Signature
15.9.11 14.9.11	be trained in this way. He thought 'appeared disordered' and he vocal paranoid and delusional ideas. He spoke about guns being hidden in a field but he did not know if 'this was true, witches and the occult and police taking "back hands"'. He also believes that there is a dead body buried in his garden but doesn't know if it is human, cat or a dog. He said that he killed a fly in his garden and red blood came out of it. He said this signifies the presence of a body. Leon spoke about his mother who he said is dying and his son who is to visit on Saturday. He also discussed his plans to go to rehab and then to be rehoused away from the dealers. He showed me superficial scratches to his left ankle which he said was a suicide attempt yesterday. He does however deny any suicidal intention or intent at time of self-harm. Leon thanked me for listening to him.	P.3 Hatcher
16.9.11 n/n	Leon requested and was given lorazepam 1mg at 22 ⁰⁰ hours and 02 ⁰⁰ hours for to help him settle. However he has been awake most of the night he appears quite exacerbated but pleasant and no management problem.	P.3 Hatcher
11.15	Leon was a bit upset this morning due to patients that Leon was friends with being discharged and also students leaving. Support and reassurance given and Leon appears more settled at present.	RM Miller V. Miller
12.15	Dr Caranagh patient review - feedback from Dr Williams * Not keen to start depot due to side effects * Agreed to start Stelazine 5mg once a day * Asked for HIV test but explained to Dr Caranagh he has not been at risk. Dr Caranagh advised test not needing done.	Allyson
19.55	Leon settled around the ward attempting to spend time at nurses station and having to be asked to move away. No concerns reported.	E. Allen
17.9.11 0630	Leon remained settled on the ward and slept well overnight. 14NN Forrest N/A Forrest	Ilhan Foster
17.9.11 11.40am	Leon has open lengthy periods of time asleep in bed this AM up on several occasions for smoking dietary purposes, remains in bed at time of reporting.	P.3 Hatcher

Patients/Client Name

Leon Cratton

Unit/CHI Number: F5L5 3833

1703751191

Date: Time:	Record of Important Information not held in Evaluation/Review/Variation etc	Signature
19/10	Presented as fairly settled this afternoon, however requested and given haloperidol 5mg pm as was complaining of auditory hallucinations. Settled at the end of report —	[Signature]
18/9/11 0645	Is bed at commencement of shift. Slept throughout no issues at night. —	S. Fast
11:35	Early to rise attended to AIDLS and diet then returned to bed. no concerns at this time. —	[Signature]
14:35	Dawn Stanley WFOT phoned regarding an e-mail she has received from Leon's mum regarding Leon's Curo's. Advised Kynwether would speak to Leon regarding this matter & feedback was to WFOT —	[Signature]
18/9/11 2045	Presenting as fairly settled throughout the afternoon evening no references made to experiencing psychotic symptoms. No concerns noted.	[Signature] S. O'Callaghan
19/9/11 0640	NK Moving up and down the ward between sleep space and dayroom. Pleasant on approach when talking to staff. Complaining of being dizzy. vital observations checked recorded as T 36.2 B/P 120/58 P 65. Re-assured. Although by staff given as required lorazepam 1mg at 2150. Requested and given paracetamol 1g at 0220 for headache and settled after and slept. —	[Signature]
12:00	Leon has spent a quiet morning around the ward, interacting well with fellow patients and staff. conversation appropriate.	[Signature]
15:15	Dr. Cavanagh's meeting. Review tomorrow.	[Signature]
20:35	Mrs. Cratton phoned asking who had given Leon her landline telephone number, as he is not to be given her home no. Leon does have her mobile no. which is fine — advised we would look into same. Leon got his mum's home no. from a fellow male pt. mum thru the fellow male patient. Phoned Mrs. Cratton back and advised her of same —	[Signature]

Patients/Client Name

Leon Cratton

Unit/CHI Number F553833/

1191.

Date: Time:	Record of Important Information not held in Evaluation/Review/Variation etc	Signature
19/11/11 20:35	Utilised PRN Haloperidol 5mg @ 18-10 hrs & Lorazepam 1mg, as per Kardex.	
20/11/11 06:00	N/R Generally settled but late to sleep requested & given PRN Lorazepam 1mg @ 01:15 hrs but remained awake until the ward until 04:00 hrs has slept from then.	Payne
13:00	Settled morning, late to rise, asleep and missed 8am medication despite prompting to rise. Complaining of lump in Right testicles would prefer to see female doctor. fellow patient brought Leon tobacco, no other concerns to note.	Edwards
20/11	Leon visible around the ward. Over familiar at times needing bandages laid down. Was heard to be having an argument with parents, attended treatment room during 1800 hrs medication for PRN given 1mg lorazepam at 1755 hrs with good effect.	Edwards
21/11	Leon approached staff to request L.I with staff, following stressful visit from family. Leon states his mother wants him to put past sexual abuse by a paedophile in the past. Leon states he feels infuriated/frustrated by this, as he is still tortured by memories of abuse. Leon therefore states he would like further counselling regarding abuse, and that he would like a member of staff to accompany him as a mediator whilst he explains his feelings about the abuse to his mother. Advised to discuss this with permanent staff, and have passed this information to S/O Hodge.	Wish Munich STW
22/11/11 06:00	Leon has spent a quiet night on the ward. Has slept for long periods. PRN paracetamol 1g given at 2200 hrs for a headache.	X X Lerner
12:30	Settled morning - nil of note. Missed 8am medication. Dr. Canavan's meeting. Awaiting Rehab. DNA 8am medication this a.m.	Payne Payne

Patients/Client Name

Leon Gratton

Unit/CHI Number:

F51538331

170375191

Date: Time:	Record of Important Information not held in Evaluation/Review/Variation etc	Signature
21/9/11 19.45	Telephone call from ultrasound department, QMH. Leon to attend for ultrasound at 11.15hrs tomorrow Leon is aware of this	Alraham Alraham
20.20	LEON HAS BEEN SETTLED AROUND WARD THIS EVENING NO NEW ISSUES OR CONCERNS	Cell
22/9/11 0600	Settled evening, requested as required Paracetamol which he received as per symptomatic relief policy. Unable to settle totally overnight up for long periods, feel as required paracetamol in at 0430. Has been more settled since.	Alraham
12.00	Early to rise. Leon would like pass to town to cash his giro. Awaiting feedback from Dr. Cavanagh. Leon attended radiology department for ultrasound. Medical staff to chase up results.	EM mbg
16.30	Settled pm. Short pass into town to Cash Giro returned appropriate, voiced concerns about 13 year old son. Stated Son has no friends and Leon concerned about same reassurance given Leon accepted.	Alraham
21.10	Very loud around the ward requiring firm boundaries at times as inappropriate comments made to staff. Appears in good humor.	EM mbg
23/9/11 00.55	Asked to speak to staff. Voicing concerns re his mum's health, thinks she looks very ill. Has what looks like burn marks on her body where she was supposed to have had moles removed. Also worried about his son, thinks he may be getting bullied at school, says he has blue discoloration below his eyes as if he is not sleeping. Also talking about the man who raped him when Leon was 14, says he still feels very angry towards him and will never forgive him. Says he feels better when given time to talk.	EM mbg
23/9/11 06.40	(NR) As required Paracetamol by due to pain behind eyes. 0145 0720 Requested as required Metoprolol 5mg as was experiencing "delusional thoughts". In bed by 0630 after being up all night, making little effort to get to chest	Alraham
11.15	Leon has been settled around the ward this am, utilised short spells off ward to go to canteen and shop at staff discretion, returning appropriately, settled around ward no concerns at this time.	K Gleason
12.00	Settled morning. From Dr Cavanagh - to have passed as wished unless drug use evident. To have ADS on return	Alraham

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

Page No. 9

Patients/Client Name LEON GRATTON	Unit/CHI Number: FS1538331 170375191
--------------------------------------	--

Date: Time:	Record of Important Information not held in Evaluation/Review/Variation etc	Signature
23/9/11 22:50	Remains settled within ward. No new issues	all
24/9/11 06:30	Went to bed early settling quickly and appears to have slept well.	all
13:20	Leon has spent much of the morning in bed, pleasant when up.	all
19:00	Leon refused to get up for his Sam medication on pleasant and appropriate. No concerns at note	all
25/9/11 06:20	(NR) Leon has been awake for much of the night despite encouragement to retire to bed. Requested as required Lorazepam 1mg at 01:00hrs as per Kardex. Also requested Paracetamol 1g at 03:55 hrs c/o headache. Eventually retired to bed at around 05:00hrs where Leon remains at time of writing.	all
12:45	Has attempted to spend all morning in BDD but discouraged from doing so. Has attempted to ADLs	all
19:30	Settled afternoon/evening around watching, continued to seek pm medication that he display no signs of requiring. No management concerns at present	all
19:40	Requested and given paracetamol 1 gram at 19:40hrs for headache	all
26/9/11 07:10	NIR Requested Paracetamol but too early to be given same. Retired to bed and appears to have slept well	all
10:35	Settled, pleasant appropriate. Sociable with fellow patients and staff.	all
19:35	No change to presentation, appearing high at times however quick to settle. Requested and given paracetamol 1g at 18:55 for tooth ache utilising paper off ward and returning appropriately -	all
27/9/11	(NR) Leon has been awake entire night. Spending much of time between bed area and day room. Noted to be laughing inappropriately on several occasions. UDS obtained with a negative result. Given Maelox 10mls at 21:50hrs c/o heartburn and Paracetamol 1g at 23:45hrs for headache.	all
12:30	Leon has requested something for a headache first thing this morning but due to distractions he did not receive it and only asked again at 12:00 - same given. However he does not feel the increase in trifluoperazine is enough to hold him and was requesting as required, which he is no longer prescribed - voluntarily accepted	all

Patients/Client Name

Leon Gration

Unit/CHI Number:

F51538331
170375191

Date: Time:	Record of Important Information not held in Evaluation/Review/Variation etc	Signature
	this but does continue to express concern about his mum.	Millar
1505	Dr Cavanagh conveyed: Dr Cavanagh to meet with Leon's mum, ^{transfer} referral to Rehab done	82
2010	Leon heard crying in his bed area this pm, when asked what was wrong advised he was upset about his mum who is terminally ill, requesting pm medication for anxiety and agitation advised that he no longer receives these, saying that he feels he has not slept for 2 days advised I would pass this over to night shift. Shortly after left ward with fellow female patient to go to go up bright and chatty at that time.	Kyleman
2011	Leon requesting night time medication early and retired to bed soon after receiving same, slept for long period overnight.	Am/21/07
12.00	Leon had a settled morning, has been prompt couple times for morning medication, attended same posing no concerns at all	Stanger/W
17.40	DR Cavanagh's Team Meeting • Dr. Cavanagh meeting with Mrs Gration (mother) today. • Rehab referral has been completed. • Passes as wishes • Dawn Stanley, w/cor meeting with mother regarding benefits.	AGraham
1940	As required paracetamol lg as per kender for headache. Given with good effect, settled otherwise	AA
29.9.11	MR Has made little or no attempt to rehire in bed. Spoke to SIN Masina, feels abandoned by his mum, thinks she should be there for him always. Also concerned that he doesn't have lasting relationships never meets the right person. Continues to worry about having cancer even though scans have shown this is not the case. Requested and given as required	
0705	Paracetamol lgm at 05.45 for headache	EIN/A Ford
1310	Initially settled, but later stormed off the ward because he was angry with porter who had blew him a kiss. Returned immediately on his own.	RM-169
1950	frequently asking for as required med. Not using distraction techniques or going off ward utilising	

Patients/Client Name

Leon Gratton.

Unit/CHI Number:

151538331

170375191

Date: Time:	Record of Important Information not held in Evaluation/Review/Variation etc	Signature
	passes. Requested and given paracetamol 1g for sore nbs as per Kardex.	Allyne
06.09.11 06:20	Has not slept at all overnight. Has spent most of his time within the day room and sitting at nursing station. No concerns noted as Leon has been settled in presentation.	CBDO, E/NO
12 noon	Settled morning no concerns at this time.	Allyne
1:45 pm	Leon has presented, as generally settled. Spending time between bed and day room. noted to be laughing inappropriately to self at times.	Allyne
17:55	Urine drug screen done earlier this morning and was negative to everything.	Allyne
21:30	Returned appropriately from pass at 01:00 pm.	Allyne
06.09.11 06:45	Settled evening, noted to be laughing for no apparent reason on several occasions. Retired following 10pm medication, and appears to have slept well.	J. O'H
11:30	Leon has remained in bed for the morning refusing to get up for 8am medication.	Allyne
20.09.11	Leon was requesting his 8am trifluoperazine this afternoon – but unable to give at that time. Leon became quite angry this evening at his ex partner who he states was telling people Leon had abused his child (who is in care) support offered and opportunity to vent his frustrations with some effect.	Allyne
2-10-11 00:30	From the start of duty Leon presented agitated and quite loud on occasion, laughing to himself without any observable stimulus. Spent short periods overnight but posing no management problem.	Allyne
2-10-11 11:20 am	Presenting as more settled than previous evening reasonably early to have attended to personal care needs by having a bath. Returned to bed for a period of time at time of reporting socialising with peers within dayroom. No issues.	J. O'H
20.10	At times laughing/giggling inappropriately. Requested and given as required paracetamol 1g as per Kardex for sore head. Shortly after asked for more as required medication as stated it would stop him giggling. Eventually accepted refusal of as required as per A Caranagh's decision.	Allyne

Patients/Client Name

Leon Grattan

Unit/CHI Number:

F51538331

CHI - 170375191

Date: Time:	Record of Important Information not held in Evaluation/Review/Variation etc	Signature
3/10/11	(NR) In bed at start of shift, appeared to sleep throughout the night	H Mitchell
1140	Initially unwilling to get out of bed for medication this morning when requested by staff. Did eventually come just as staff were finished. Given medication at this time but advised if need to attend for medication at appropriate time. Otherwise reasonably settled and bright going off ward for short periods to shops	GR
24 Sep	Dr Conaghan meeting + points as wishes + Referral to Rehab being done. + complained of lumps under arms → Dr Conaghan advised upon surgery examining lumps he feels they are rather fatty lumps or cysts → Dr Conaghan plans to ask Dr Williams to refer Leon for Surgical Review + Leon asking for as required medication after discussion → some not prescribed. Leon approached staff asking for something to calm him down. Advised that Dr Conaghan had not prescribed him any medication however Leon stated that Dr Conaghan had agreed to prescribe medication. Informed Leon of what Dr Conaghan had discussed + agreed with staff regarding as required medication being prescribed. Also informed Leon Dr Conaghan had advised myself that he had informed Leon that he would discuss need for as required medication with staff. Leon stated that he was to have surgery for lumps under arms. Advised Leon that Dr Conaghan was planning to arrange a surgical review of his lumps. - Also informed Leon that it could be discussed with Dr Conaghan regarding as required medication being prescribed. Leon replied he would "fit" his	

Patients/Client Name

Unit/CHI Number:

Leon Gratton.

F5153837
1 10 575191.

Date: Time:	Record of Important Information not held in Evaluation/Review/Variation etc	Signature
220pm	arise out the door th . Leon walked away at this time. Later approached staff saying he would not "flee or run away" out the door" & that he only wanted a once only of medication to feel better. He lumps in his lymphatic system.	Setham
730pm	interviewed about periods off work spending time in company of fellow patient. Wine drug screen obtained same negative to all things tested for. Settled in presentation at time of writing notes.	Setham
20 th 5	1:1 with Leon this evening. He continues to express that there are poisonous spiders in his flat, that he has avoided being killed on numerous occasions and about various superstitions. Leon spoke about concerns about his mum and also about concerns about his biopsy - is concerned she has cancer as has had the lumps under his arm for quite a while. Leon also spoke about his previous drug taking and life style as a teenager and also about his anger at his ex-girlfriend Vivienne for telling another ex-partner of hers, he had abused his son - he was upset even at the thought of this. 1:1 interrupted by events on the ward.	W. T. H.
03 24/10/11 0635	Mumky settled late evening, requested and given as required Paracetamol 1g at 0140 for tooth pain, retired around 0200, and has slept well since this time.	Jal
370pm	Arrived later in am. Refused to accept 8am medication, more for Leon. did not receive 8am medication. Laid in manner of tired, but pleasant in approach. Mood appears bright; continues to giggle to self at times.	Setham
2050	still unable that not receiving any as required medication. States does not like liquid trifuoprazine, would	

Patients/Client Name

Leon Gration

Unit/CHI Number:

45753833
1703751191

Date: Time:	Record of Important Information not held in Evaluation/Review/Variation etc	Signature
	prefel tablet form, Cate/Ged asked during staying Leon had advised a COT support worker, who was visiting ward tonight, that his mum had died. Advised Leon had not let any of nursing staff know this information and likely he would inform same. 13/10/11 NR Up till late spending time between and bed space. On approach ch complaining about different things, eventually settled and slept. 13/10 Leon spent morning on his bed asleep. Did get up for morning medication, but returned to bed immediately afterwards. 14:00 Dr Cavanagh's Team Meeting • Mental State Stable • Awaiting rehab Stratheden • Continue present care • Passes as wishes. 1930~ Rose for evening meal. Has spent all other time on bed, despite prompting. 6/10/11 NR Leon up most of the night only spending short period in bed; required boundaries at times as wanting to sit at nurses station. 6.10.11 Settled morning on the ward. Amenable on 11.40. approach. Requested paracetamol for a sore back, given 1mg paracetamol at 11.15hrs. No concerns at this time. 6.10.11 Staff from Falkland Ward will visit ward 1520 on 13/10/11 @ 2pm to assess Leon. 19.40 Taxi called for Leon to Inverkeithing post office to cash his cheque. Leon made his way back the ward without a problem. He requested and given paracetamol 1g as he complained of having headache. Leon remained settled in manner socialising with fellow patient no concerns noticed. 6/10/11 PLEASANT ENTRY - LEON WAS OBSERVED ON 3/10/11 GOING TO THE COOL APPEARED LAUGHING AND RELAXING TO SOMEONE AND APPEARED OVER THE INFLUENCE OF ILLEGAL SUBSTANCES.	Alyson Quinn Colles Abraham Stewart AMASIWA T. Burns EM mbg Stungashid Scott

Patients/Client Name

Leon Grotton

Unit/CHI Number: F5153833

1703751191

Date: Time:	Record of Important Information not held in Evaluation/Review/Variation etc	Signature
7.10.11 (NR) 06:45	Leon has been awake for much of the night. Heard to be laughing whilst in the bathroom and when asked if he was OK was heard to slap himself. Requesting as required medication, despite none prescribed.	R Singh
11:55h	Refused 8am medication. Settled in presentation this a.m. No evidence of laughing or self harm. Noted in an odd embrace with fellow female patient.	Simmons
19:40	Leon has been in the company of other, he could be inappropriate at times in conversation with staff, he was pleasant in manner with no concerns.	SBan
5.10.11 (NR) 12:05	Informed staff that other female male patient had left word to go to Elizabethan pub, also stated that patient was in possession of Cannabis. Settled night on ward, slept for long periods.	KSingh
19:10	Appears settled on ward, requested as required paracetamol for toothache. Given same at 11:30hrs, states will organise dental appointment next week now that has money for transport.	Allymer
4/10/11 06:30	Settled on ward, no concerns to note. NIR Leon appeared settled although pushing boundaries at times by standing over patients door and talking in a loud voice when other patients are sleeping. Firm boundaries applied. Requested and given paracetamol 1g at 22:00 for headache. Appears to have slept well overnight.	Allymer
11:40	Up for 8am meds but returned back to bed, remains there at time of writing.	Allymer
19:45	Leon has spent time chatting to me informally. He is worried about going to Stratheden as he has heard negative stories about it and thinks there are a lot of criminals there. I have spoken to him about what his options are, perhaps needing to go home instead, at that point he agreed he needed to go to Stratheden. Leon has had a fairly settled evening.	Malik

Patients/Client Name

Leon Gratton

Unit/CHI Number:

F5153833

170371191

Date: Time:	Record of Important Information not held in Evaluation/Review/Variation etc	Signature
9.10.11 0835	Falkland ward contacted ward today to say that a Rehab pathway should be completed and sent with risk assessment to Falkland before Leon is assessed on Thursday. We have no forms so Falkland will send these to us.	Edwards
10.10.11 0640	NIR No change in presentation up and down the ward between bed space and day room. Accepted 10pm medication eventually settled after midnight and slept.	Andrews
15 ⁰⁰	Dr Cunningham review. - concerned re going to rehab at Stratheden and getting money when up there - Nursing staff rehab coming to see Thursday. - move coherent in some conversations. - continue passes as wished. Leon has had a quiet morning up for his morning medication but most of rest of time in bed.	
19.30	Settled nil of note to report	McIntosh
11.10.11 0705	NIR Restless and noisy around the ward giggling loudly Requested and given Paracetamol 1gm at 02:55 for toothache. Slept little overnight.	EINA Ford
11.30	Leon presenting as settled since being wished to see medical staff psoriasis / eczema / psoriasis patches on both elbows → medical staff should be advised of same	Sims
12.00	Dr Williams aware that Leon wishes to have elbows reviewed, due to ? eczema / psoriasis on same	Sims
19.30	Settled in presentation, no feed back from Dr Williams regarding above note. Leon interacting well with peers	
12.10.11 06.30	Leon remains settled in presentation, requested and given PARACETAMOL 1gm at 00:45hrs for toothache. Slept for short periods only overnight	C. Reid
12.10.11	"Dr Cunningham meeting" - waiting to be assessed by Stratheden Nursing staff regards Rehab placement - Passes remain unchanged, can go as he wishes	Slingshot
19.00	Bright and settled in presentation, No concerns -	SL

Patients/Client Name	Leon Grafton	Unit/CHI Number: F5153833
		170371191

Date: Time:	Record of Important Information not held in Evaluation/Review/Variation etc	Signature
1530	Referral to reharb done, copy of fax sent to Kenny Thompson, Falkland ward. Nursing Referral & Risk Assessment has been sent by fax to Dumfries ward.	BO
2045	Settled during this duty no new concerns	Ch
13/10/11	Generally settled, has remained up all night making little effort to go to bed. Made as request Paracetamol 1g at 2210 and at 0255 for toothache.	Ch
1310	Giggly at times, utilising short passes appropriately.	EM-mbg
1930	Settled day, assessed by Reharb staff. No concerns of note.	BO
14/10/11	Requested for Paracetamol for toothache at 22.15hrs. Awake for most of the night. Spent long periods in the dayroom. Giggling inappropriately at times.	EPH
1150	Has spent majority of the morning in bed refused to rise for some medication despite several prompts. Rose at 1145 due to Mr William wishing to speak with him, no feedback at this time. Currently awaiting feedback from Falkland re suitability for Leon to be transferred, no concern at this time.	K Glenon
1955	Settled on ward, requested and given as required paracetamol 1g at 1810 for sore head.	Allymer
14/10/11	Remains settled in presentation. Requested and received prn Paracetamol 1g at 02.10. 15.45 and soft paraffin at 03.30 for dry skin on his elbows and feet. Slept only for short spells, spending time between his bed area and dayroom.	EPH
1200	Leon has appeared settled, requested and was given Prn Madox 10mls & 1g paracetamol at 10.40.	BO
2000	Appearing generally settled. Approached staff stating that his 'pulses' were going through the roof and that he had chest pains, though he had not smoked for ages. Vital obs T-35.9°C BP 140/77, P-72 at this time. Leon suggesting that perhaps his symptoms were due to anxiety. Staff in agreement with this. Leon advised to attempt relaxation or go for a walk. He declined to do so.	Allymer

Patients/Client Name	Unit/CHI Number:
LEON CRATTON	F5153833 170371191

Date: Time:	Record of Important Information not held in Evaluation/Review/Variation etc	Signature
16.10.11 06:20	Settled in presentation retiring to bed at 01.00hrs. Has slept for long periods at a time however up on a few occasions for smoking purposes. Requested and given pm paracetamol 1gm at 21.45hrs to headache.	QBO & W CBO & L
11:30	Late to rise, refused to get up and attend for 8am medication. Quiet in presentation, most time Spent asleep in bed. No other concerns offered. E Duffly	
20:00	Initially settled. Went to CO-OP & ON RETURN OBSERVED TO BE MORE EXCITED - PSYCHOMOTOR AGITATION CONVERSATION LOUD & GIGGLING. OBSERVED LEAVING RECREATION ROOM TRYING TO HIDE A LARGE CAN OF SOMETHING. WHEN ASKED TO SHOW THIS TO STAFF HE SAID IT WAS "COKE". THEN RAN INTO HIS ROOM. STAFF FOLLOWED & FOUND A LARGE CAN OF ORANGE ENERGY DRINK IN HIS LOCKER. ALSO FOUND WERE EMPTY CARBONATED CONTAINERS FOR 16 ENERGY CANS. THOSE WERE REMOVED FROM LOCKER. LEON ADVICE THAT THOSE DRINKS WERE NOT ADVISABLE TO DRINK AS THEY AFFECT SLEEP PATTERNS. STRONG SMELL OF CIGARETTE SMOKE DETECTED IN SHOWER AREA. LEON DENIED IT WAS HIM BUT NO OTHER PATIENTS AROUND AT THIS TIME. LEON PRESENTED AS VERY KEEN TO GO BACK INTO RECREATION ROOM. STAFF SEARCHED THIS ROOM & FOUND 3 MORE CANS OF ENERGY DRINKS. SAME REMOVED & PLACED IN STAFF CUPBOARD WITH ONE OF THOSE DESTROYED AS OPENED. LEON REMAINS AGITATED AT TIME OF WRITING.	all
17/10/11 06:15	Client settled in presentation on ward. Up throughout the night on numerous occasions for cigarettes and drinks, posing no management issues. Requested and gives paracetamol 1gm at 22.25hrs and again at 04.20hrs.	S. Faint &
12:00hrs	Early AM Leon was very loud, shouting out in distress, continued giggling at times. Seems to have settled a bit now. Nothing else to report.	Aimee J. McPherson
13:20	WARD MEETING • Awaiting result of ROTHAS interview.	all
15:00	DA contacted to advise of admission date.	Aimee
15:00	Leon advised of above	Aimee
20:15	Leon spoke to myself this evening. He is worried about his mother who is unwell and was due to receive biopsy results today. Spoke of his relationship	

Patients/Client Name	Unit/CHI Number:
Leon Gratton	F5153833 170371191

Date: Time:	Record of Important Information not held in Evaluation/Review/Variation etc	Signature
	with his parents. Spoke of often consuming alcohol ^{energy} drinks. Feels it's better to do this, then take drugs.	A Graham
18/10/11	(NR) Requested to speak with Doctor as he complains of paracetamol and paracetamol doesn't work, Doctor was busy and unable to see Leon, Therefore, gave a prescription for Ibuprofen 400mg t.i.d alongside Paracetamol 1gm. Given @ 01.00hrs. Spent short time in the dayroom and retired to bed and slept well throughout the night.	H Mitchell
12 ¹⁰	Generally settled, given as requested Ibuprofen 400mg at 10 ²⁰ for generalised pain. No concerns.	Atter
14 ²⁵	Contacted Dunning ward, rehab allocation meeting will take place on Thursday the 20/10/11 at 2.30pm. Staff from ward 2 to contact them at 3.30pm on Thursday.	E Deftor
19 ⁵⁰	Leon fairly settled around ward. Talking loudly at times, will quiet down when spoken to about this. Spent time off ward to (OO) appropriately.	Colle G
19/10/11	(NR) Awake most of the night, loud in manner, laughing inappropriately. Many physical complaints. Seeking out staff on numerous occasions. Stated on one occasion he wanted staff to "take an axe to his head and drain the blood away". Requested and given broken dreams at 1.05hrs. All night pacing from bed area to dayroom, Making his presence known throughout the night.	H Mitchell
15 ²⁵	Dr Cavanagh's Meeting - No changes to his passes - No change on medication to continue as per Kardex * Rehab nursing staff feedback on the 20/10/11 at 15.30pm.	Colle G Stanger
	This morning Leon attended to his personal care. He continues to be laughing loud to himself. After lunch went to bed, observed asleep.	Colle G Stanger
20 ¹⁰	Using pass appropriately. Settled evening.	Atter
19/10/11 07 ⁰⁰	Requested and received Paracetamol 1g and Ibuprofen 400mg at 21.45 hrs. Has slept well since 22.30 and remains asleep at time of report.	Atter
12 ³⁰	Settled morning, seen by Dr Bennet - Surgeon 12: has recurrent axillary abscesses. To have four wick	Atter

Patients/Client Name

Leon Grafton

Unit/CHI Number

25753833
17037191

Date: Time:	Record of Important Information not held in Evaluation/Review/Variation etc	Signature
	Cont of Flucloxacillin then review by Dr Bennett query possibility of Surgery. PRN Paracetamol 1g for toothache as per Kardex. Settled at present	EDdyb
	740pm Generally settled in presentation, however loud F vocal at times - Required to be asked to keep volume down at times. Spent time scribbling with pens + short periods off world. Wound crabs not further increase. Allaying up leg	
	740pm Clonazepam 500mg as per Kardex. Re-assessed + given paracetamol 1gram at 1530hrs + Ibuprofen 400mg for at 1530 for general pains + toothache	11/11/11
21/10/11 0645	(NR) Requested and given as required Ibuprofen 400mg at 22:50 and Paracetamol 1gm at 01:55 c/o toothache. Spent much of time in dayroom in company of fellow patients. Late to settle to bed. Slept long spells.	K. Singh
10:50	Early to rise, attended for 8am medication, loud and vocal at times. Received as required paracetamol 1gram and Ibuprofen 400mg for tooth pain. No further complaints offered regarding same. During ward contact, meeting not held on Thursday decision will be made this Thursday and they will contact ward regarding same. No other concerns	EDdyb
19:30	Leon was Presented Settled, no change in presentation how PERSISTS within BED SLEEP, Bed Area. hand at times	EDdyb
22/10/11 0640	(NR) Leon retired to bed early however when awake overnight appearing excitable and laughing inappropriately. Slept for short period overnight. Spoke briefly to staff about foul smelling feet reported to have athletes foot and has no socks to wear with shoes, also stating feet were broken & sore may require review by medical staff to rule out fungal infection. UDS required due to possibility of misusing illicit substances overnight.	Amazawa
1120.	Continues to laugh & giggle inappropriately. Complaining of sore/? infected ear, being reviewed by duty doctor at time of writing. UDS to be done.	RAMING
1200	Ears reviewed by duty doctor, no concerns,	

Patients/Client Name

Leon Gratton

Unit/CHI Number: FS153833

1703711191

Date: Time:	Record of Important Information not held in Evaluation/Review/Variation etc	Signature
	only a build up of wax noted. Prescribed olive oil ear drops. Leon was asked by C/N Graham why he was giggling inappropriately. Leon reported that he was reliving funny moments from the past. Leon was searched on return from the shop, which he agreed to. No alcohol or illicit substances found.	EM mbg
20.4.15	No change in presentation. Time spent within day. Leon / Ben Spack. Leon at times still to obtain urine sample settled at time of report.	F. Ainsworth
13.10.11 (WR)	Asked to speak to myself. Stated 07:10 that another patient was going to bring drug called 'white magic' onto ward when he returns from pass. Leon also feels that it is time for him to move on. Loud at times, in presentation. Retired to bed around midnight and has slept well.	K Singh
12.3.15	Leon came early, ill. Headache. Medication requested paracetamol for headache. at 08:30hrs. Again requested 1bn paracetamol for headache at 12:15hrs. Leon eventually settled, no evidence of giggling to self. Leon is fine.	S. I. Mearns
16.15	Met with Leon this afternoon. He admitted to bringing in alcohol, Vodka, to the ward on Friday night and sharing with another patient(s) whom he could not disclose. Leon assured me that this would not happen again. Also confirmed that another patient was planning to bring in "white magic", but he doesn't think that this was brought in. Said he wouldn't personally use "white magic" because it killed some of his friends.	EM mbg
19.50	Leon asked if the police would be coming to see him about 'the white magic'. Spoke of having brought in a wasp spider that he had killed recently and had shown this to a member of night staff. Stated this spider was orange and black in colour, and that it had dangled down	

Patients/Client Name		Unit/CHI Number:
Leon Gribben		F5153833 1703711191
Date: Time:	Record of Important Information not held in Evaluation/Review/Variation etc	Signature
	at his door and he had killed it as it is deadly. Stated this type of spider can kill people and that a neighbour had died of an unknown cause. Overfamiliar at times in conversation. loud and giggling in manner at times. Unable to provide a Urine Sample for urine drug screen, when asked by N/A Aitken.	Abraham
24.10.11 06:50	(NR) Requested and given as required Paracetamol 1g at 22:10hrs. Spent time in company of fellow patients before retiring to bed around 23:30hrs. Appears to have slept well overnight.	K Singh
1200	FROM DR. CAVANAGH • Due to bringing in alcohol and risk of bringing in drugs, Leon's passes have been stopped. • Leon will be reviewed by Dr. Cavanagh tomorrow. Leon has spent all morning in bed, only rising for medication.	RAA mbs
1415	Requested and given as required paracetamol 1g at 1820hrs for toothache. Visited hymn and step-dad this evening. Outbursts of laughing at times after visitors left.	Alyman
25.10.11 06:45	NIR Leon admitted to me (EIN Ford) that he had hidden Vodka from me on Friday night when I asked what he had. He says he should have given it up, that he is a 'happy drunk' and went to sleep on Friday night, he questioned what had happened later. Was told this could not be discussed. Requested and given as required Paracetamol 1gm at 23:25 for earache. Slept for long periods.	EIN A Ford
13.05	Anakin for 08:00hrs medication, active around ward chatty and pleasant, no management concerns.	E Aitken
1930	Seen by Dr. Cavanagh, feedback taken from doctor's notes: - • No change to mental state • awaiting decision from rehab. • Reiterated no alcohol policy. Leon apologised for bringing in alcohol last week.	RAA mbs

Patients/Client Name

Leon Gratton

Unit/CHI Number: FS153833

170371191

Date: Time:	Record of Important Information not held in Evaluation/Review/Variation etc	Signature
25/10/11 1935	Leon has spent time between star bed area and music room, interacting well with peers. Seeking PRN's on occasions, discouraged against same.	RAHMBG
25/10/11 0640	Settled evening, requested and given as required Paracetamol 1g for toothache. Retired and slept well, shouting out in his sleep on one occasion.	J. Paul
1415	De Cavanagh team meeting - Awaiting feedback from Rehab - Continue current care plan	
1416	Settled on ward, no concerns	RB
1930	Bright and pleasant on approach. Giggling and laughing inappropriately at times.	RAHMBG
27/10/11 0615	NR) Leon reasonably settled, Ibuprofen 400mg at 2220 for sore tooth, retired early and appeared to sleep well overnight, requesting move from dorm to single room, complaining of foot smell in dayroom dorm and wary of fellow patient B.P.	AMAGIWA.
1315	Settled morning. No change in presentation.	ALL
1830	Settled day, however requested paracetamol 1 gram at 14.15 for tooth ache and Ibuprofen 400mg at 16.15 for same. Leon advised to contact Dentist regarding this but Leon states won't go due to phobia of the dentist	RB
28/10/11 0620	For some time from the start of duty Leon was noted to be laughing to unknown stimulus, although his attention could be gained away from this stimulus. Requested and given PRN paracetamol and Ibuprofen as per Kardex for ear/headache. Set in dayroom for some time before retiring to bed, appears to have slept well.	AMAGIWA.
1130	Continues to complain of various physical symptoms. Given as required paracetamol 1g as per Kardex for generalised pain. Otherwise settled.	ALL
2020	No change to usual routine. Continues to seek PRN pain relief for various pains	ALL
2030	From De Cavanagh - CAN HAVE UNOCCURRED PAINS IN CO-OP.	ALL
29/10/11 0600	Continues to request pain relief for physical symptoms, received PRN Paracetamol and Ibuprofen at 0000 hrs. Late to settle into bed and periodically up throughout the	

Patients/Client Name Leon Garton	Unit/CHI Number: F5153833 1703711191
-------------------------------------	--

Date: Time:	Record of Important Information not held in Evaluation/Review/Variation etc	Signature
29.10.11 NR	Night. At times loud and laughing to himself but no management concern.	OTG
07.00	Requested and given prn paracetamol 1gm at 06.40hrs c/o earache.	GBG EK
1.20	Satisfied maximum Time Spent within Day Room watching T.V and listening to music. Still to attend to ADAS. Loud at times throughout.	E.Aim
19.30	Generally settled. Continues to complain of general aches and pains. Given as required paracetamol 1g at 16.00 and Ibuprofen 400mg at 19.00 with settling effect.	off
29.10.11 NR	In bed asleep at the start of night duty and required to be wakened for his carry out meal. Leon accepted his 10pm medication together with and retired to bed. He appears to have slept well overnight only waking on two occasions overnight. He got up at 6am and has been settled and relaxed in manner.	P.3.11
12.30	Leon presented as slightly brittle first thing this morning, he also came out of the music room stating someone was crying, unaccepting that I could not hear anything. Leon has started to staff at different points - continues to be upset about mafia and peoples attitudes. He also continues to be concerned about other clients.	W.11.11
21.00	Leon requesting to meet with duty doctor this evening, as states he has a headache. Received paracetamol 1g prn as per kardex. Spoke at times laughing loudly - this has been observed on a few occasions this evening when in ward corridor.	A.11.11
30.10.11 NR	Retired to bed early and has slept well overnight. On rising requested and given prn Paracetamol 1gm at 05.45hrs c/o headache. Noted to be laughing loudly to self at times.	GBG EK
12.25	Being over familiar with other patients, their conditions, medications and eating habits, not accepting when they are telling him its none of his business, invading of others space at times.	Rev.

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

Page No...35..

Patients/Client Name

Leon Gratton

Unit/CHI Number:

F5153833

1703711191

Date: Time:	Record of Important Information not held in Evaluation/Review/Variation etc	Signature
2010	Leon fairly settled. Requested pm paracetamol with 1800hrs medication this given at 1850hrs. No concerns reported.	
1-11-01	Settled evening, retired to bed and appears to have slept well overnight.	
n/a	around 2 uspm Leon slammed door of his room loudly. Stated that no one had come to see him, that he had a black eye + broken finger. From incident this am. Advised Leon that Dr Connors was aware of incident this am + will be coming to see him. Sam condrops not given as Sam being retained due to incident at 07.55hrs this am. (Retrospectively entry from Sam 11/11/01). Duty doctor contact to ask/confirm for and only of Olive. Oil for ear drops that Leon missed this am. Leon presenting as irritable + demanding at times.	
1-11-11	Leon has remained isolated within confines of his single room throughout the afternoon/evening, diet provided within this setting. Presenting as generally settled, visited by his parents this evening. No concerns noted.	
19-10-06		
2-11-11	In bed asleep from the start of the night. Settled - presentation and appears to have slept for long periods.	
07-10	Settled evening, time spent within bed area and on occasions in dayroom.	
1030		
3-11-11	Leon has remained awake for the duration of the night, making no attempt to retire to bed. Majority of the night was spent in his side room, openly and loudly responding to unknown stimuli. When outside of his room and walking down the corridor, Leon could resist laughing or talking to himself. Accepted regular 10pm medication but made no attempt to retire. Also requested and given Paracetamol 1g and Ibuprofen 400mg at 2225 hrs.	
0630	At the beginning of duty an ex-patient phoned the ward on 3 occasions requesting to speak with Leon. Leon was advised of these calls but presented annoyed that this ex-patient was phoning. Very soon after these calls Leon was heard talking in his room about a	

Patients/Client Name

LEON GRATTON

Unit/CHI Number:

F5153833
1703711191

Date: Time:	Record of Important Information not held in Evaluation/Review/Variation etc	Signature
	Sum of £30 which was owed by Leon, but which Leon had no intention of paying.	DMG
3/11/11 1135	RETROSPECTIVE ENTRY: from 2/11/11 1pm: - Leon received PRN paracetamol 1 gram yesterday morning as per Kardex for sore head. Spent long periods in his room, refusing to come out.	RM
1250	Belated entry from 2/11/11 pm. Leon requested to see medical staff as felt two fingers on his right hand were broken. Reviewed by Dr. Ferman - feedback given - 2 fingers are not broken. Strapped with mepore tape, gauze swabs in between fingers. Fingers are bruised, not swollen. Leon complaining of having pain in them.	A. Graham
1550	Leon remained in single room (retrospective entry from 2.11.11). Throughout morning. Heard to be raising voice and banging around in the room on a number of occasions. Initable at times. Expressing annoyance at being in single but also saying he would not go into day room while fellow male patients involved in the incident on morning of 1.11.11 were still in the ward.	Elle
1630	At 11am approximately, an ex-patient ^{Brian Paterson} and an unknown male stating his name was William Briggs, entered the ward, walking past staff member sitting at desk at ward entrance stating they were going to speak to Leon as he owed 'Brian Paterson' money. They were both asked to sit outside main entrance of ward. William Briggs stated he had lent Leon £40 two months ago and he had arranged for this to be repaid to him today, once his giro was cashed. I spoke with Leon regarding this matter and he refused to see them. When they were informed of this, they were insistent Leon had to pay £40. They wished him to pay their taxi fare to and from the hospital to Inverkerthing. Stated they couldn't collect their money other than today. Shv Muvumba was present at this time, and they agreed for him to give their mobile telephone numbers to Leon. They requested Leon's telephone number. Craig Security officer was present on the ward at this time.	

Patients/Client Name

Leon Gratton

Unit/CHI Number:

F5153833

1703711191

Date: Time:	Record of Important Information not held in Evaluation/Review/Variation etc	Signature
	and was present when I spoke to Leon again. Leon stated he wasn't going to give either of these men his mobile number and stated he was concerned for his safety, stating they both carry knives on their person. Stated he had been assaulted by William Briggs before, and had had his house windows panned in previously. Security officer + Leon requested police be contacted to attend ward due to safety issues that may present to staff + Leon, when these men were asked to leave hospital.	
	Three police officers attended ward and spoke with myself, Chris Graham, Craig Security officer and Leon. Leon informed them money requested by these two men were for drug debts, which he wasn't going to pay anymore. Stated they had "panned" his windows in previously and had previously assaulted him and had been demanding money from him for a long time.	
	Police officers met with Brian Patterson and William Briggs in handover room. Feedback from Craig, Security officer - Police located no knives on either male and were asked to leave hospital premises. Police stated if they turn up at ward 2 again, not to be allowed to visit Leon and police to be contacted.	AGraham
3/11/11 13.30	No change in his presentation, can be loud at times. Settled in the ward this afternoon, spent his time in the dayroom with fellow patients. Leon was requested urine for UDS test, Leon report that can not pass urine, Night staff are to try Leon to supply urine. Leon requested and given PRN paracetamol 1g @ 13.35 for pain.	Ellen Stanger
3/11/11 NR 06.45	Requested and received Paracetamol 1g and Ibuprofen 400mg at 21.50 for general body pains. Retired to bed and appears to have slept for long periods. Heard shouting out on one occasion, for no apparent reason.	Ellen

Patients/Client Name

LEON GRATTON

Unit/CHI Number:

FS153833

170371191

Date: Time:	Record of Important Information not held in Evaluation/Review/Variation etc	Signature
4.11.11 0720	Retrospective entry from 3.11.11: phone call received from SCA Williams from Dunino ward at Stratheden. Rehab meeting had taken place that afternoon and he advised that after reports that Leon was not doing well it might be better if he stays in ward for now and is referred again to rehab in the future. Dr Connagh aware and will deal with situation.	Ch. Skingsen
1205	No change in presentation, still he continues to complain of pain and need of pain relief. This morning he requested and given Paracetamol 1g at 10.55. Spent his time with fellow patient in the dayroom. Posing no concern up to this time.	Ch. Skingsen
4.11.11 1940	Leon has presented as generally settled this P.M. socialising at an appropriate level with other clients requesting and given Paracetamol 1gm at 17.10 for pain relief. Urine Specimen obtained and P.D.S carried out which proved negative to all illicit substances on drug testing card.	Ch. Skingsen
4.11.11 0720	Received prn Paracetamol 1g and Ibuprofen 400mg at 07.20. Spent some time in the company of a fellow new patient. Appears to have slept well.	Ch. Skingsen
1220	Early to rise this morning. Time spent between bed area and dayroom.	Ch. Skingsen
2000	No change from above notes. Time spent between bed area and dayroom. Requesting prns, complaining of headache given paracetamol 1gram with bpm medication. No concerns of note.	Ch. Skingsen
6.11.11 (NR)	Requested and given Brufen 400mg at 21.50 for headache. Seeking out staff on numerous occasions. Spent time in company of fellow patients before retiring to bed. Slept long spells.	Ch. Skingsen
1050	No change in presentation, spending time between bed area and dayroom. No complaints of pain so far.	Ch. Skingsen
6.11.11 1945	No change in presentation, continues to complain of pain, requesting and given IBUPROFEN 400mg.	Ch. Skingsen

Patients/Client Name

Leon Crattan

Unit/CHI Number:

F5153833

CHI- 170371191

Date: Time:	Record of Important Information not held in Evaluation/Review/Variation etc	Signature
6.11.11 19.45 hr	at 19.05 hrs appears to be socialising at an appropriate level with fellow clients. no other concerns to report.	B.D. Gallagher
7.11.11 (NR) 06.40	Presentation remains unchanged, continues to seek out staff. Had as required Paracetamol 1g at 21.55 and Brufen 400mg at 23.35. Settled in bed sleeping quietly. Slept well.	
11.30	Leon attended for 5am medication and has since returned to his bed where he remains asleep at time of writing.	B.D. Gallagher
11.11 11.40 hr	Unmotivated to rise this AM, duration of the morning spent asleep in bed, remains there at time of reporting.	B.D. Gallagher
21.11	Leon continues to want to speak to staff quite a lot and was involved in a loud discussion about visitors over the weekend. Mostly settled.	M. Tinkler
8.11.11 06.30	PRN Paracetamol as per Kardex. Settled into bed and has slept well.	B.D. Gallagher
1pm	Settled, no concerns to report. Time spent in Parlour, within main Room. NOT YET ATTENDED TO ABOUT 1.30pm	B.D. Gallagher
19.40	Settled in the ward. Leon requested PRN for headache and given 1g paracetamol at 15.50. Appropriate in manner. No concerns to report.	B.D. Gallagher
9.11.11 (NR) 06.25	Requested and given Paracetamol 1g and Brufen 400mg at 21.45hrs C/O vomiting, aches and pains. Looks settle to sleep but has slept long spells.	B.D. Gallagher
11.50	Quiet and settled in the ward. Friendly to staff and other fellow patients. No concerns to report at present.	B.D. Gallagher
14.30	Olive oil ear drops not given at 8am as Leon states his ear feels better. Dr. Williams to be asked to review. Leon informed by myself that a male patient due for discharge today, is waiting on £30 he lent him during admission. Leon stated this was not the case but that this person was acting on behalf of Willie Briggs for drug debts of £30, which Leon states he doesn't owe but will	B.D. Gallagher

Patients/Client Name

Leon Grattan

Unit/CHI Number:

F5153833

CHI: 17 03711191

Date: Time:	Record of Important Information not held in Evaluation/Review/Variation etc	Signature
9.11.11 19.15h	pay to this male patient, to get Willie Briggs off his back. presenting as fairly settled throughout the afternoon/evening. periods of time spent asleep in bed. Visited by his Mother and Sister this evening. at end of visit Leon's Mother spoke briefly with myself expressing concern that Leon will go home and who has been told by neighbours drug dealers have been to his home looking for him. informed Leon's passes are currently within hospital. His Grattan will contact ward tomorrow to speak with S/N Duffy to discuss her concerns and arrange money to be given to Leon whilst she is on holiday next week.	A. Graham
19.35h	requesting and given Paracetamol 1gm at 18.35h for pain relief.	J. A. Gallagher
2035	Patient who was discharged today came onto ward to collect money from Leon. Leon willing to give money, no animosity between both parties.	Alyson
10.11.11 06.20	(NR) Remains settled in presentation - Requested and given Paracetamol 1g at 23:10hrs as per Kardex. Settled and slept well overnight.	K Smyth
11.30	Leon has been quiet and settled in the ward. Attended morning medication went back to bed. No personal hygiene attended. Later was up, spent time in the classroom, sociable to peer group. No concerns voiced by Leon at this time.	E. Duffy S/N S. Langast/N
1940	Leon has been fairly settled around the ward this pm. Keen throughout pm to sit at Nurses station and asked to move on occasion for confidentiality Requested and given paracetamol 1g at 18.15 for toothache with some effect.	K. Leman
11.11.11 06.30	Retired to bed early. But requested Ibuprofen 400mg + 1gm Paracetamol at 22.55hrs. Settled to sleep soon after.	J. A. Gallagher
10.55	Retrospective entry from 10/11/11 regarding a telephone call from Mrs Grattan received at 12.30am. Mrs Grattan has been attending Leon's home to clean it up, whilst there a fellow patient from ward approached Mrs Grattan and was threatening in manner. Mrs Grattan informed this individual that should	

Patients/Client Name

Leon Gratten

Unit/CHI Number:

75153833
1703711191

Date:
Time:

Record of Important Information not held in Evaluation/Review/Variation etc

Signature

Cont any harm come to Leon then the police would be contacted. Leon's mother will be away on holiday until the first week in December and wishes money to be kept in the internet but Leon is not to have the money all at once as it's to last 2 wks. Leon is also to receive a further benefit payment whilst they are away and his mother will leave a further £80 in an envelope which Leon is not to know about until it is most to be due.

From this morning, Leon requested asked a fellow patient to buy him energy drinks from the co-op. Same were confiscated and placed in storage. Firm boundaries were given to Leon regarding the consumption of these drinks within the ward environment and the negative effects i.e. anxiety, restlessness and effect on mood. Leon accepting of same. Quiet the rest of the morning. No other concerns reported to staff.

1950 Generally settled. Given as required paracetamol 1g for headache, with good effect.

12.11.11 Requested for 1 byprofen 400mg at 21.45
NR and Paracetamol 1g at 00.40 for body pains. Appears to have slept for long periods. Heard to be laughing and giggling inappropriately in the day. He said he had had a funny dream. Advised to have consideration for fellow patients. Leon apologised for his behaviour.

12.11.11 Leon was evident at start of this duty, overfamiliar
11.35 in conversation content when interacting with staff. Following diet he returned to his bed where he remains at time of reporting.

13.15 Leon requested prn paracetamol 1gram at 13.00hs for headache.

17.30 Leon has been inappropriate at times with ward when in corridor or passing nurses station. No concerns noted.

Patients/Client Name LEON GRATTON	Unit/CHI Number: FS153833 1703711191
---	--

Date: Time:	Record of Important Information not held in Evaluation/Review/Variation etc	Signature
12/13/11 06.45	Requested for Ibuprofen 400mg at 21.45. Settled in presentation and appears to have slept well overnight.	SPR
1300	Rose with prompting for 8am medication as per Kardex. Met with Leon regarding sitting at nursing station and at corridor area. It was explained to Leon regarding confidentiality and rolling cigarettes in the corridor. Leon accepted boundaries. Attended community meeting. Settled nil complaints offered.	EDuffy
1940	17 with Leon this evening at his request. Leon presented as initially quite stressed and agitated spoke about feeling he cannot approach staff now. He spoke about the sewer at his house and how he thought there was one (at least) dead body outside down the sewer, he had had the council out to it and they have advised him someone has probably poured concrete down it. He does not believe this. Also he spoke about an ex-patient at his house with a hemp plant - and concerns he had about a hemp spider he saw on them (they can kill you). Again spoke about the orange and black spider at his back door which will kill him as it is poisonous. Leon spoke about the state of society, the mafia and people previously assaulting him. He also spoke about being in the TA and doing 22 towers of duty - although it was unclear if he thought just helping people was one of these. He spoke about hearing shots outside the hospital again - states he can identify when it is a proper gunshot rather than fireworks or anything else. Leon was at times difficult to follow and the subjects did appear to be causing him some anxiety. Over 101 he did become calmer.	MM Intosh

Patients/Client Name LEON GRATTON	Unit/CHI Number: FS153833 170371191
---	---

Date: Time:	Record of Important Information not held in Evaluation/Review/Variation etc	Signature
13/14.11.11 NR 06.40	Generally settled in presentation. Requested and received Paracetamol 1g and Ibuprofen 400mg at 21.50. Complained of heartburn sensation and tasting bile in his mouth. Given Maalox 10mls at 01.30 as per symptomatic relief policy. Noted to be eating and doing his roll ups at the nursing station. Given firm boundaries about this. Slept only for short periods.	
07.15	Requested for Paracetamol 1g at 07.00hrs for a sore head.	EDP
12.10	Dr Cavanagh review - Dr Cavanagh will phone rehab after seeing Leon tomorrow. Leon has been up and about this morning continues to express concern about other clients.	EDP
19.45	Continues to loiter at nursing station and treatment room despite firm boundaries. Eventually accepted shower and spent time in dayroom and courtyard. No other concerns.	EDP
15/11 06.15	NR Remains settled on the ward requested and given PRN Paracetamol 1g & Ibuprofen 400mg @ 22.00hrs for headache. Returned to bed by 23.00hrs and has appeared to sleep well overnight.	EDP
1.45	Prompted to rise on several occasions for 8am medication despite previous conversations regarding same. Settled all complaints offered.	EDP
15/11/11	<u>DR Cavanagh's Patient Review</u> - Complaining of headaches still. Rehab feel Leon is still more unwell so feel not appropriate to transfer. Describing "flashbacks" of "gunfire" and "fireworks". Says he has seen keys being given to patients by staff → gaining access to drugs. Having thoughts of wildlife TV programmes, no distress. Sleeping ++. Not been to O/T (says not to be as ED been arranged). Plan Refer for O/T assessment.	EDP
19.20	No change in usual routine. ENJOYED A VISIT FROM	EDP

Patients/Client Name

LEON GRATTON

Unit/CHI Number: FS153833

170371191

Date: Time:	Record of Important Information not held in Evaluation/Review/Variation etc	Signature
	PARENTS THIS EVENING. THEY WILL BE GOING ON HOLIDAY FOR TWO WEEKS ON SATURDAY & WILL TAKE LEON TO COLLECT HIS MONEY ON THURSDAY HE WILL PUT HIS SECOND WEEKS MONEY INTO INVEST SYSTEM. Mum will also leave money, without TELLING LEON TO COVER HIM FOR THURSDAY - SATURDAY TIL THEY RETURN	all
1940	BOUNDARIES REQUIRED AT TIMES	all
16/11/11 01:00	Continues to present as settled around the ward. mixing with fellow patient. Requested and given PRN Ibuprofen 400g @ 21:45 for headache. Retired to bed by 00-30h slept well	all
16/11/11 12:40	Presenting settled in the ward, spent his time in the day room with fellow patients. Achieves adequate food and fluids, and attends for needs. At this time Leon reported having chest pain and requested, and given as required Paracetamol 1g at was given at 12.40. Observations taken. Pulse 81. Temp 36.6. B/P. 126/64. Sats 97%. Leon advised by nursing staff if having more pain he is to rest in bed also he is to try to have more fluid intake.	Almes
1940	No further complaints of chest pains on the back shift. Time spent between bed area and dayroom. Loud at times, but no management problems.	Stangor/N
16/11/11 06:30	Requested and given Ibuprofen at 21:45. Loud and pacing along the ward. Noted to be sleeping in dayroom with his feet on the table. Encouraged to go to bed, which he did. Has slept well since 02:30.	Almes
1125	Inappropriate comments at times throughout morning. Requested prn paracetamol with morning medication. Dne gram offered and accepted at 0825hrs. Took himself back to bed. No concerns.	all
5pm	From Dr Williams Leon's Ibuprofen + antibiotics have now been discontinued.	Sims
19:00	Leon went out this afternoon to	

Patients/Client Name

Leon Crichton

Unit/CHI Number: F5153833

1703711191

Date: Time:	Record of Important Information not held in Evaluation/Review/Variation etc	Signature
cont:	meet up with his mum. Returned later with mum. She was handed £100 which has been placed in the imprest. She wishes Leon to be given money cautiously and £50 at least was not to be given to him before 1st December 2000. Leon has had 1g of paracetamol as per wardbox.	Agf
18/11/00 16:25	N/R No change in overall presentation. Sleep pattern has been poor up and active on many occasions. Paracetamol 1g @ 22-10 hrs and again @ 06-15 hrs for headache.	Agf
11:40	Leon has remained settled this morning. Has been asked on several occasions to move away from Nurses station which he did with no complaints. Is in dayroom at time of writing.	Agf
17:35	O/T Referral complete and sent with copy of risk assessment. Copies can be located at back of nursing notes.	Edg
20:15	Leon spending most of time in bed area. fairly settled. Requested pm paracetamol at 19:05 for headache, 1 gram offered. No concerns from Dr Caranaghs review. • Trifluoperazine increased. Cannot read remainder as illegible.	Edg
19-11-00 (NR) 06:35	No change in presentation. Retired to bed around midnight and appears to have slept well.	K Singh
12:05	Leon remained settled this morning, rose for 8 am medication, returned to bed. All concerns.	Edg
19:20	Settled afternoon/evening. No concerns to note.	Edg
20-11-00 (NR) 06:30	Awake entire night. Requested to talk to staff. Spoke of having hallucinations, but believes that they are real. Given as required Paracetamol 1g at 21:40 and 04:25 hrs as requested for headache and toothache.	K Singh
11:25	Leon has had a quiet morning, he was out at the 10-11. Nil news of concern.	Wint

Patients/Client Name

Leon Gratton

Unit/CHI Number:

F5153833

170375191

Date: Time:	Record of Important Information not held in Evaluation/Review/Variation etc	Signature
2005	Requested and given paracetamol 1g at 1815 hrs for back pain. Quiet on the ward. Went in bath later, stating was "shattered". Heard to be singing whilst in bath, this continued when out of bath, asked to reduce volume of singing, which he did.	Alymer
21.11.11 06.30	NIR Continues to seek out staff, ordered take away food. Returned to bed, and slept well overnight.	EN A Farcl
21.11.11 R 2014	Leon has spent duration of the morning asleep in bed. remains there at this time of writing	J. A. Gallagher
12.50	Dr Cavanagh Kardex Review Informed Dr Cavanagh regarding Leon's mobile being used to make calls to a fellow patient's ex in-laws. Advised that unsure if Leon or fellow patient made calls. Dr Cavanagh advised that Leon has had a history of making similar calls to family.	
	Plan - Has been referred to O/T - Awaiting 6 week assessment at rehab Strathclyde	EDuffy
1935	Leon has spent majority of time in dayroom interacting well with others. Short pass to Coop and returned appropriately. Requested and given paracetamol 1 gram for sore neck.	EN A WBS
22.11.11 0630	Leon approached staff complaining of painful area on his penis. There is indeed a small broken area which is a little bit inflamed and has a small yellow pus-like centre. Leon states that this is red and is size since yesterday. Advised to keep clean and dry and to let staff know if worsens. Given Paracetamol 1g for sore back. Has slept for only short periods overnight.	EN A WBS
1400	Requested and given as required paracetamol 1g for pain at the back of his head. No further complaints.	Alymer
19.30	No change in presentation, less intrusive with staff this PM. Renowned as required diclofenac 50mg at 18.35hrs for back pain, no other concerns to note.	EDuffy
23.11.11 0630	Quiet presentation. Indeed only slept well for long periods, less intrusive into staff personal business noted.	EN A WBS
1215.	No concerns noted.	EN A WBS

Patients/Client Name:		Unit / CHI No.	R5753853	Care Plan No	
LEON GRATTON			170375191		
Date:	Record of Evaluation and / or Review				Signature
2000	Settled on ward, requested and given prn diclofenac 80mg 50mg at 1835. No other concerns.				[Signature]
24/11/11 NR 0600	Note to settle spending long periods of time in dayroom chatting with others, had Paracetamol 1g at 2155 for headache, again at 0325. Retired to bed after 0330. Slept well since.				[Signature]
12.15	Appears settled in presentation, less intrusive when staff has morning. No concerns voiced regarding pain in his head or his back or (chest).				[Signature]
1950	Leon has utilized short passes and been pleasant and appropriate on superficial conversation.				[Signature]
25/11/11 NR 0640	Leon has had a settled night. Received 1g paracetamol at 2150 at his request. Went to bed at around 2345 and slept throughout the night.				M Corbett
1203	Early to rise this morning. Time spent between bed space and dayroom. Withdrew £20 from safekeeping for tobacco.				[Signature]
1205	Dr Cavanagh review. Mental state stable. Refrals to come to reassess. Prescribed Piroctifen for migraines.				[Signature]
1940	Complaining of migraine headache. Heard to be shouting/ swearing, stating same was due to headache. Given boundaries. Accepting of same.				[Signature]
25/11/11 NR 0640	Unhappy due to migraine medication being unavailable however requested and given prn paracetamol 1gm @ 22.10hrs. Again had to be reminded not to loiter around nursing station. Took £20 out of ward safe for carry out meal of which he shared with fellow patients. No concerns. Has slept well.				[Signature]
1145	Leon has been up and about this morning, pleasant, on interaction.				[Signature]
20.10	No change in presentation. Time spent between bed area and dayroom, cautioned for smoking purposes. Requested and given paracetamol 1 gram at 16.10hrs for headache. No other				[Signature]

Patients/Client Name:		Unit / CHI No. F5153333 170375191	Care Plan No	Signature
Leon Cretton				
Date:	Record of Evaluation and / or Review			Signature
Cont	concerns to report			EDfly
26/27.11.11	Given pin paracetamol 1gm at 22.20hrs /o headache			
06.30	instead of prescribed medication of which has still to be discussed with the doctor as it was noted that it is not advisable to be given when taking hypnotics and antidepressants. Leon is on both these medications and was accepting of the decision to omit it meantime. No concerns overnight. Leon has slept well for long periods.			ABC dhu
11.05	Prompted to rise for 8am medication, eventually rose for same. Had breakfast, not attended to ADL'S. Returned to bed, no other concerns to note			EDfly
1930	Leon has remained settled this evening, some inappropriate comments, but accepting boundaries			mm5mth
27/28.11.11	Leon stated the new migraine medication had helped and the headache was gone. Has slept for long spells. No concerns noted.			SPH p.
12.00	Leon has spent the morning in his bed.			aght
12.05	Dr Cowanugh review. - discussed concerns re protocol with Dr Cowanugh aware and has prescribed it for him to have. - awaiting referral to see him			mm5mth.
1930	Leon has presented as settled this evening ordered a takeaway, no concerns voiced			Q
29/11/11	N/A Settled in presentation last night retired to work early and has slept well overnight			
06.55				
12.10hrs	Leon settled, no concerns to note.			SPH p.
4.10pm	Dr Cowanugh patient review & information from Dr Williams re feedback from meeting. & Refab to review Leon on again? When & continue with plan of care			Starrm
Fr. 20	Leon has been settled no concerns.			aght
29/30.11.11	Settled in presentation. Slept well overnight.			SPH p.
06.10				
1.10	Prompted to Rise for 8am medication, also to attend to ADL'S long periods lying in bed throughout			

Patients/Client Name

Leon Hyatt

Unit/CHI Number:

FS153833
170375191

Date: Time:	Record of Important Information not held in Evaluation/Review/Variation etc	Signature
	UP AT lunch time. OFF WARD AT SHOP STILL TO ATTEND TO HIS ADL'S ALSO SORT OUT HIS LAUNDRY.	E. Aitken
2020	Heard to be shouting in dorm on one occasion. Settled otherwise. Complaining of lumps reappearing under arms. Dr to be informed.	HL
11.12.11 07:00	Asked to speak with staff. Stated that he didn't want to go to rehab due to hearing stories about a patient who had choked and the staff just watched this happen. He expressed concern about the experience of the staff there. Given reassurance regarding this. Leon realises that rehab would be a better option for him than going home and knows he would resume to his previous lifestyle. Does not want to go back home ^{there} because people are after him and will likely kill him. Leon retired to bed early and has slept well overnight.	ABQ tla
11/12/11 1130	Leon has spent all morning in bed. Not attended to personal care despite prompting.	RM mbg
	Falkland Ward coming to assess on 3 December @ 2pm.	RM mbg
19:30	Leon informed about rehab. Staff from Falkland Ward, Stratheden coming to assess him on 3/12/11. Leon aware from Dr Williams that he is to have an ultrasound taken tomorrow of cysts under armpits. Settled evening. Spent on ward.	A Graham
2-12-11 0600	Leon has slept for very short period only overnight although posed no management problem. Spent time between sitting room and bed area. Requested and given as required paracetamol 1gm at 02:00hrs. Has not attended to personal hygiene.	MClate
11.5pm	Dr Williams reviewed feedback from Dr Williams in Rehab to review Leon on Saturday 3/12/11. Leon to stay on ward that day until seen by Rehab. Dr to have ultra sound in afternoon for lumps	

Patients/Client Name

Leon Granton

Unit/CHI Number:

T5153823
170375191

Date:	Record of Important Information not held in Evaluation/Review/Variation etc	Signature
Time: 11.5pm		
2/12/11	under arms	S. Lyons
11.5pm	Settled morning on ward	S. Lyons
1900	Ultrasound to be done next week, re lumps under his arms. Paracetamol prescribed as regular now. Also prescribed antibiotics by Dr. Williams. Requested and given PRN diclofenac 50mg at 1800 hours for some head.	BAH/bs
3/12/11	(R) Examined by surgical registrar last night. Advises that antibiotic therapy continues and if no improvement evident by Monday then surgeons to be contacted with the possibility of abscess under arms being drained. Leon has been settled overnight and slept long spells.	K. Sign
11.45	Leon has remained in bed all morning –	AM/John
2010	Pharmacy sent up 400mg metronidazole, but prescribed 500mg. Duty doctor advised oral dose is usually 400mg. S/N A. Syme and S/N M. McIntosh took instructions from duty doctor to administer 400mg, with agreement doctor would change Kardex when on site later today.	A. Syme
4/12/11	Leon met with S/C/N from Rethas yesterday afternoon. She felt he was suitable for Rethas but would discuss this with medical staff Mon 5/12/11 then advise Ward 2 of Hox decisions. S/C/N stated Leon was mostly appropriate in his conversation only deviating from topic on a couple of occasions. Leon also advised Hox he would be happy to go to Stratheden. S/C/N said she hoped transfer could take place sooner rather than later.	AP
2015	Leon has personally settled on ward no change to usual routine.	AP
1:1 session	– Leon thinks he has HIV and would like a test. • States that ex-girlfriend might have infected him • Leon is worried about lumps under his arms, advised him that an ultrasound has been requested. • Complaining of itchy genitals and thrush "for some time now". Would like to be referred to GUM clinic.	

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

Page No... 51

Patients/Client Name

Leon Grafton

Unit/CHI Number: F5153833

1703751191

Date: Time:	Record of Important Information not held in Evaluation/Review/Variation etc	Signature
4/12/11 2030	Leon states he would be happy to go to rehab. During visiting time, Leon walked away from his mum whilst in the day room. Says he wasn't happy with her mum because she kept talking about Leon's ex partner - Liz. Requested and given PRN diclofenac 50mg at 1950 hrs for headache.	RMA mbc
5/12/11 0650	(NR) Slept long spells. Awoke early morning. Spent time in dayroom. Hard to be laughing to himself on several occasions. Settled morning. Long periods spent in bed. Appointment made for GUM clinic on Friday 11 am. DR. CAVANAGH MTNG: Await feedback from rehab. • continue with passes. No changes. — • HIV test at GUM clinic if insisting.	K Singh
1945	Leon settled in presentation. Evident around ward. No concerns of note.	RMA mbc RMA mbc
5/12/11 0620	Settled and has slept well for long periods.	Attoul
5/12/11 1145	Leon has spent the majority of the morning in his bed, rising briefly at medication time but returning to bed almost immediately. He appeared belatedly to us after shift promptly. On rising he has appeared over familiar with shift.	SRP ps
1805	Dr Cavanagh's review: Awaiting feedback from rehab. Rehab staff to contact. Ward tomorrow —	LS Light sk.
1910	Leon spent time off the ward on return he has been socialising with other male patients there where no concerns.	SBain
7/12/11 0635	NIR Continually seeking out staff and passing trivial comments. Slept little overnight, spending time in the sitting room. Requested and given Diclofenac Sodium 50mg at 21.00	EN A Ford
1250	Dr Cavanagh reviewed - accepted by Rehab - 3 broken bed will be available - OT completing functional assessment.	MM Intosh
1245	No change to usual routine. Arranged more making with OT at time of writing.	RPL

Patients/Client Name

LEON GRATTON

Unit/CHI Number:

Date: Time:	Record of Important Information not held in Evaluation/Review/Variation etc	Signature
1920	Telephone call received from Falkland ward.	
7/12/11	A bed is available for Leon, but transfer can only be done next week after Rehab Wards meeting on Thursday 15/12/11. Leon has been pacing corridor on occasions. No concerns noted.	RW vls
1940	Telephone call received from Leon's mother. She was enquiring if Leon would be allowed to maintain his tenancy when he went to rehab. Staff to speak to Dr Cavanagh regarding this tomorrow and contact Leon's mother. She was also given update on Leon's presentation.	Atter
22.02	Telephone call received from Leon's mother. Stated Leon had informed her that he had been given information by Dr Williams which had upset him. Leon's mother wishes to speak with the Doctor for clarification. Advised to call during the day.	ERPs
8/12/11 0600	Settled and well. Retired to bed early and has slept well overnight.	Atter
1120.	Leon spent most of the morning in bed, however did approach me to ask if a fellow client was ok as he had heard he would have had "blow" and indicated collapsing with his hand. He also spoke about his hand and opening it and making a fist and mentioned it being broken which it is not.	Atter
19.00	From Dr Williams - She contacted haematology, who asked her to speak to breast clinic regarding lump under his armpits. They advised Leon to have a biopsy of the lymph nodes - Dr Williams completing a referral for this. Dr Williams spoke with Leon regarding referral, and spoke with Mrs Gratton (mother) via telephone. Leon has remained settled in presentation throughout the evening.	A Graham
9.12.11 06.20	Requested and given prn Diclofenac 50mg at 23.00hrs for general aches and pains and also stated that it helped alleviate the pressure in his head. Leon has slept only a short period overnight spending the majority of the night within	

Patients/Client Name

LEON CRATTON.

Unit/CHI Number:

F5153833

1703751191

Date: Time:	Record of Important Information not held in Evaluation/Review/Variation etc	Signature
8.12.11 NR 06:20	the dayroom. Required to be reminded on a couple of occasions to keep his voice down to enable others to sleep.	
9/12/11 11:50	Leon has appeared brittle at times. Continues to wear the same clothes as yesterday. Prompted to change by staff. Left ward to attend GUM clinic. No feedback given on his return.	CIBO s/n.
1300	DR. CAV. MEETING • awaiting rehab. • mental state appears stable	W.T. GHA s/n.
2000	Appears settled on the ward, no concerns to note	RM m/s
10/12/11 06:15	Leon slept for long periods of time then up early in the morning. Leon had to be reprimanded as found smoking in the dayroom. Was then found smoking again very shortly afterwards in the dayroom. Leon has been laughing inappropriately.	Almes
12:00	No change to usual routine. Urine sample carried for U.O.S. NEGATIVE TO ALL	McCorbett
2020	Reviewed by Dr re fluoxetine to be discontinued has had it for 1 week. From Duty Dr Leon still has redness under armpits. So fluoxetine to continue	MC Smith Ch Ch
2021	No change in prescription	
11.12.11 NR 06:00	Loud in manner. Continues to laugh inappropriately at times. Retired to bed and slept from midnight.	
11.12.11	Leon overinvolved with others, disappointed, brittle in manner. Requested 10pm medication given @ 12:20 hrs, as seeking PRN pain relief	CIBO s/n.
	Attended the community meeting	(Payne)
20:00	No change in usual routine	(Payne) Ch
12/12/11 NR	Found Appears to be overinvolved with fellow patients and attempting to listen to conversation between staff and patients. Found Prior to retiring smoking in day room. Reminded about the policy. Requested and given diclofenac at 21:30 for headache feels paracetamol not working therefore refused at 10pm. Smoking again in day room this morning. Reminded of smoking policy.	W.M. s/n.

Patients/Client Name

Leon Hayton

Unit/CHI Number:

F5153833
H0345191

Date: Time:	Record of Important Information not held in Evaluation/Review/Variation etc	Signature
12.20	NO CHANGE IN PRESENTATION, CONTINUES TO PACE THE CORRIDOR, WANDERING AROUND NURSING STATION. STILL TO ATTEND TO HIS ADVICE AND CHANGE OF CLOTHES. ALSO SEEKING MEDICATION. NURSING STAFF ASKED HIM WHAT THE MEDICATION IS FOR, LEON DID NOT ANSWER AND THEN CALLED THE TREATMENT 1400 R. Caranagh clinical review. * Fluoxetine and metronidazole now discontinued. * Await rehab.	Allyne
1405	Earlier Leon asked for as required meds due to really bad pain in toothache. Asked if able to contact his dentist yet, stated can't get hold of them. Then stated has no money to phone dentist as his mum controls his money. Asked if mum can phone dentist, but stated she cannot. Stated to Leon he appears to be making excuses for not contacting dentist. At that point he said "Oh Faye, you're saying my mums an excuse" and stormed off to his bedside. No further complaints re toothache from Leon.	Allyne
2005 12/12/11	Continually seeking PRN pain relief, same not given, advised to use regular paracetamol. Vital obs done, same within normal range. Requesting PRN dihydrocodeine for "swelling" of his brain - advised to discuss same with medical staff tomorrow. Continues to pace corridor.	EM mbg
13/12/11 0700	Accepted 10pm meds, consider pain continues, appears very displeased but after we get him some of things. Has slept very little after waking around 0300, pacing now apparent, intrusive behaviour not so evident however, lunging out and not hitting himself.	Allyne
13/12/11 10:25	OCCUPATIONAL THERAPY 1 to 1 breakfast session 09:00 - 10:10. Leon was affable but his conversational topics were erratic and quite macabre. He stated that someone had been trying to poison him. Some of his stories did not make sense. He was able to locate items in kitchen, describe process for preparing bacon rolls and carry out the tasks involved. He had poor concentration and needed prompting to wash hands initially after touching bacon. He followed hygiene precautions thereafter. Plan: to continue 1-1 meal making sessions.	Continued BBAH/OT Kirsten Powell OT student
13/12/11 1940	Leon has appeared brittle on approach by staff. He has spent long periods in his bed area, intermingled with time in the day room and courtyard (for smoking purposes).	cont'd

Patients/Client Name

LEON GRATTON.

Unit/CHI Number:
F 5153833/

170375191

Date: Time:	Record of Important Information not held in Evaluation/Review/Variation etc	Signature
1940 13/12/11 cont	Appears appropriate when interacting with fellow patients, however intolerant of another male patient in the same bay (An)	L. Light S/
1140 0630	Appears restless, pacing up and down corridor. Accepted 10pm medication without fuss. Requested and given as requested Diclofenac 50mg at 2245 with a very good settling effect. Leon has remained asleep in bed since	[Signature]
1140	Time spent between bed area and court yard for smoking purposes. No concerns noted.	[Signature]
740pm	Leon has presented as settled this pm. Noted to be socialising well with fellow clients. Has voiced no concerns tonight. Enquired if he was still prescribed antibiotics, upon checking Leon's Kardex no antibiotics prescribed → Leon informed of this	[Signature]
MR 15/12/11 06:00	Leon settled on ward spending time in day room and courtyard. Sat in corridor for a while watching staff asked Leon to return to dayroom. Retired to bed. Slept well overnight	[Signature]
1255	Leon presented as slightly agitated this morning at the thought of having to collect his benefits. However did manage to go out, returning with a "subway". Moved settled since and chatting to fellow clients	[Signature]
1800	Random urine drug screen done. Negative to all. Leon has presented as settled this evening spending time mostly at bed area. No change -	[Signature]
16/12/11 (PR) 06:40	Slept for long spells overnight, although up for cigarette on several occasions.	[Signature]
1140hrs	Initially generally settled. Complained of headache viral onsewaria taken Bp 115/68 Temp 35.8° p 75 + 02sars 98°/2° Drained snot. Interaction with DR Forman who had DR William review. Legend Leon headaches. DR Forman advised staff to give Leon an 100mg Diclofenac Sodium → same given at 12:00pm.	[Signature]
17.10	Contacted Dunino ward regarding which ward Leon would be going to for six week assessment. S/N informed that she knew nothing about same and that they had Leon recorded as still	[Signature]

Patients/Client Name

Unit/CHI Number:

FS153833
170375191

Leon Gratton

Date: Time:	Record of Important Information not held in Evaluation/Review/Variation etc	Signature
Cont	requiring assessment for same. Advised that SCN Gibson had spoken with S/N Linda Grumbach who informed her that the SCN from Dunino would contact ward 2 today with the details. Advised them that Leon has already been assessed by Dunino Staff and that Dr Cavanagh had consulted with medical staff and that a six week assessment had been arranged. Awaiting call back from SCN.	E Duffly
17:30	Senior Charge Nurse from Dunino contacted ward to inform staff that normally patients would be transferred the first week in January. Advised that would be preferable if Leon could be transferred at first convenience. Will contact ward tomorrow with date.	E Duffly
20:00	Leon wandered down the corridor and into his bed area, he was overheard swearing. I went to speak to him, initially appeared slightly on edge, but accepting of 1:1 time. He appeared upset with his mum at this time and also spoke about up his dad not being in touch and he is meant to be up here this week.	MM Intoh
16/12/11 0640	NR) Leon reasonably settled early evening, requested and given Diclofenac Sodium 50mg at 2145hrs for ongoing headache, retired to bed around 2330hrs and appeared to sleep well overnight.	AMASIWA.
	Leon has remained in bed much of the morning and has been out to the shop, settled in presentation.	MM Intoh
1400	Leon's blood pressure raised this afternoon - requested & received PRN Diclofenac 50mg @ 15.25hrs. Settled evening - nil of note.	U Paape
16/12/11 0650	NR) Leon noted to be smoking in bed area; eating a Chinese meal and had drunk x2 Energy drinks; firm boundaries reinforced and reminded of ward policy regarding eating food in bed area and hospital smoking policy, x2 cans of Energy drink also confiscated. Leon presenting as loud, accelerated with pressured speech also laughing out inappropriately at times. Retired to bed after 10pm medication and settled with prompting slept well overnight.	AMASIWA.
1150hrs	Awake early, no evidence of gissing to self.	

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

Page No. 57

Patients/Client Name

Leon Gratton

Unit/CHI Number:

F51 53833
170375191

Date: Time:	Record of Important Information not held in Evaluation/Review/Variation etc	Signature
18/12/11 11.50am	Asked to go to shop. Advised not to buy high energy drinks as the caffeine in some may be contributing to his high headaches & advised these are not allowed on ward. Leon became bristly & stormed off ward when staff spoke about these drinks & contributing to his headaches as denied this & stated it made his headache go away. Returned from shop 15 minutes later after leaving. Currently lying in bed at time of writing notes.	S.M.M.
19/12/11 19.40	Leon did request to speak to someone but when his keyworker went to speak to him he was asleep. He received diclofenac sodium after eating his tea this evening for pain in his hand. Leon has had a bath this evening.	M. J. J. J.
19/12/11 06.30	(MR) WAS IN BED AROUND 10.30pm APPEARS TO HAVE SLEPT WELL OVERNIGHT.	E. N. A. F. J. J.
19/12/11 12.25	Leon has spent much of the morning in bed sleeping. Occasionally up and quite loud.	M. J. J. J.
19/12/11 13.00	Dr Cavanagh - Kardex Review Rehab want to transfer on 6/1/12. Say there will be no O/R input until New Year Plan	M. J. J. J.
19/12/11 14.40	Nursing Staff to discuss plan with rehab. Presenting as generally settled throughout the P.M. with periods of time spent resting in bed also following several short phases off the ward, returning appropriately. Requesting and given Diclofenac Sodium 50mg at 14.20 hrs for pain relief. Visited by his Mother this evening who spoke briefly with myself and told her Leon was riddled with cancer from head to toe. Leon Gratton making light of this and appearing to be aware of the situation and his appointment at clinic tomorrow. Leon Gratton reported his father is coming from Manchester tomorrow and will visit Leon on ward at 13.00 hrs and accompany him to his appointment at Breast Clinic at 3.15 hrs. He would also like to meet with a staff	E. D. J. J. J.

Patients/Client Name

Leon Grattan

Unit/CHI Number

F 515333

CHI 170375191

Date: Time:	Record of Important Information not held in Evaluation/Review/Variation etc	Signature
14.12.11 19.40 hrs	member for an update on Leon's progress. Leon Grattan went on to say they will collect Leon at 16.00 hrs on Xmas day to take him home for dinner and also to meet his Son who will be there.	J.D. Callaghan
20.12.11 06.35	NIP continues to offer help to staff with jobs around the ward, Diclofenac 50mg given at 02.05. B.H.C. in mood when up for a cigarette around 01.30, other wise slept well.	EINA Ford
20/12/11 12.35	Leon rose late. He visited the shop at 11.05. briefly. On his return, visitors attended the ward, one of which was Leon's father. Leon proceeded of the ward with them to the coffee shop.	J. Taylor
17.3	Nil from Dr Cavanagh's meeting.	M. Smith
19.15	Leon was supposed to attend the breast clinic today at 15.15hrs with his father who was visiting from Manchester. At 15.45hrs Leon was noted to lying in his bed asleep. When asked if he had attended his appointment Leon said that he had forgotten. Leon was asked why he didn't attend the appointment with his dad. Leon said that he had told his dad not to bother had then went to bed slept. Leon was reminded that it was him that was anxious to be examined at the breast clinic, but Leon said I'm sorry I forgot. Went off ward for short period to ASDA. Mum and step dad visited Leon this pm, Leon's mum was annoyed with Leon for not attending his appointment. Leon has spent the rest of the evening between music room and dayroom. No other concerns.	E. Duffin
21.12.11 06.40	Quite disgruntled as DVD player not worked. Retired to bed and has slept well overnight.	P. Hall
12.10	Prompted to rise, given firm boundaries with regards to personal care i.e. foot care. Proceeded to have a bath. Spoke with Dr Williams regarding missed appointment yesterday. New appointment made for breast clinic on 10/1/12. Leon to be transferred to Dunning Ward on 6/1/12 during handover time this has been confirmed by SGT White. Settled otherwise.	E. Duffin
	DR. CAVANAGH MEETING: • Dr Williams to chase up another appointment with the breast clinic. • Staff to escort to appointment.	EINA Ford

Patients/Client Name

Leon Wotton

Unit/CHI Number:

FS153833
170375191

Date: Time:	Record of Important Information not held in Evaluation/Review/Variation etc	Signature
20 ⁰⁵	Leon requesting diclofenac sodium - same given but only after he had eaten his tea. Settled evening.	
21/12/11 07:00	Requested Diclofenac at 10pm but not allowed due to time of previous dose. Retired to bed. Fell asleep sleeping until 01:30, but Diclofenac at 01:50 returned to bed thereafter.	MM Tufel
11:30	Quiet morning, time spent lying in his bed, showing concern for others.	MM Tufel
20:25	Settled, visited by step dad today. Requested and given PRN diclofenac 50mg for headache as per kardex.	MM Tufel
23/12/11 06:05	Settled evening, retired to bed at 11:30 & still sleeping at time of writing. No concerns.	MM Tufel
12:05	Dr. Cavanaugh Meeting	MM Tufel
	• Transfer to rehab 6/01/12.	
	• tired, headaches	
	• mental state ok	
	• Passes as wishes, Leon has nothing planned for christmas.	MM Tufel
	Leon has been settled this morning.	MM Tufel
16:00	Received non-standardized assessment form from OT. Filed at back of nursing notes.	MM Tufel
19:30	Leon settled, evident around ward. No concerns.	MM Tufel
20:30	Given as requested diclofenac 50mg at 20:30 for headache.	MM Tufel
NR	Settled within the ward prior to bed. No concerns noted.	MM Tufel
24/12/11 06:30	Leon retired to bed early and has slept well overnight.	MM Tufel
24/12/11 11:50	Leon has spent long periods in his bed area. Prompted to attend to his personal hygiene but appears reluctant to do so. Accepted 0800 medication.	MM Tufel
15:30	Leon was assisted by myself S/N Duffy to complete post office form for his benefits to be paid into.	MM Tufel
19:50	Settled day, spent with peers in dayroom. No concerns of note.	MM Tufel
25/12/11 06:30	Settled in presentation. Requested and given prn diclofenac 50mg at 21:35hrs for headache.	MM Tufel
	No further concerns. Has slept well.	MM Tufel
11:25	Leon has attended to his personal care, no concerns noted.	MM Tufel

Patients/Client Name Leon Gratton	Unit/CHI Number: PS153833 170375191
---	---

Date: Time:	Record of Important Information not held in Evaluation/Review/Variation etc	Signature
13.30	UAS Negative.	<i>[Signature]</i>
20.00	Leon has appeared settled, pleasant on approach. He left for a period off the ward to visit his mother. He returned appearing happy. No concerns.	<i>[Signature]</i> s/p
20.15	Approached staff stating he was suffering pain, given as requested diclofenac 50mg at 20.15hrs.	<i>[Signature]</i>
26.12.11 06.30	Presenting generally settled within the ward in the evening time. Retired to bed and appears to have slept well overnight.	<i>[Signature]</i>
11.45	Leon has spent long periods in his bed. He rose for his 0800 medication and returned to bed. Leon attended a Ward Community Meeting regarding a patient being given illicit drugs on the ward. Leon contributed to the discussion on the ward, stating that others have been taking drugs but denies involvement or ever meeting such 'dodgy characters' who supply drugs there.	<i>[Signature]</i> s/p
26.12.11 19.10.11	Presenting as generally settled throughout the afternoon evening, voicing no complaints or concerns noted.	<i>[Signature]</i>
27.12.11 06.30	Generally settled overnight, settled early to bed and has appeared to sleep well.	<i>[Signature]</i>
27.12.11 19.45	Leon received a visit from his mother + step-father, who requested to speak with myself. Mother stated she had been informed by Leon that he was being transferred to rehab, Stratheden on 6/1/12. Mrs Gratton has requested to 'go up with Leon when he is transferred, so she can provide support. Leon still has his house in Inverkeithing, parents have cleared out all the mess, still have some things to do. She stated Leon can't go back to his house for his own safety. She visits his house regularly to check on it, and has told certain people to post money back that they owe Leon through his letter box - and they are abusive at this time. Mother is concerned that if Leon gives up his house, he will lose more benefits. Stated she has heard that Stratheden Hospital would want Leon to give up his house so they can claim his benefits - advised I was not aware of this. Mother is worried if her son gives up his house, this will make him intentionally homeless. Leon is due to get a new kitchen + bathroom installed. Gas meter has been checked.	<i>[Signature]</i>

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

Page No. 60...

Patients/Client Name

Leon Gratton

Unit/CHI Number:

F5153833

170375191

Date: Time:	Record of Important Information not held in Evaluation/Review/Variation etc	Signature
	Mrs Gratton stated Leon has had no heating from last January - Stated "Haldane House should have known" Leon's back windows of house have been painted blue, and door previously kicked in. His good furniture is in storage at parent's garage books + bookcase still to be moved. On 29/12/11 his mother will collect him to cash his benefit and see his son for a few hours. Mother has ^{completed} a post office application form, as post office to stop paying by giro and will start putting money into post office account/bank account. Leon has decided to get a post office account. Mother plans to be at biopsy appointment, QMH when rehab staff escort Leon to appointment. Leon asked to decide what to do about his debt.	
28.12.11 0645 1240	No concerns overnight settled in presentation prior to retiring to bed. Has slept well. Settled morning - Evident around ward. No concerns.	A. Graham
28/12/11 2030	Reporting as generally settled throughout the P.M. no concerns noted although continues to complain of headaches, requesting and given Diclofenac 50mg at 15:50 hrs.	J. A. Callaghan
29/12/11 0630	NIR Leon appeared to be in good at the commencement of the shift interacting with staff and fellow-patients. Slept fairly well with short spells in bed although from 0400am. Requested and given diclofenac 50mg as per cardex for sore back.	Records
29.12.11 12 noon	Early to rise this morning, unsure go to attendance to diet or personal care needs. Relatively settled in his presentation. Leon is currently on short pass into town to collect his benefits and meet his mother. due to return to the ward 14:00 hrs.	J. A. Callaghan
2030	Presenting as generally settled throughout the day. Voicing no other complaints.	
30/12/11 0635	NIR Leon reasonably settled with no complaints offered retired to bed early and appeared to sleep well overnight waking around 0500hrs, requested and given Diclofenac 50mg at 0615hrs for back pain.	
30.12.11 11:40 am	Settled morning, no change to presentation or issues to report	J. A. Callaghan

Patients/Client Name

Leon Gratton

Unit/CHI Number:

F S153833

170375191

Date: Time:	Record of Important Information not held in Evaluation/Review/Variation etc	Signature
1210	Leon has appeared settled. He has utilised passers off the ward to go to the co-op to acquire items for other patients (bag checked on return)	L2ylk
15:05	1:1 with Leon Gratton regarding transfer to Durness ward for 6 week assessment on 6/1/12. Leon aware that his move to Durness is for a 6 week assessment at present, Leon also confirmed that Dr Cavanagh discussed some test ^{PM} ^{EO} with him previously. Leon also said that he could not return to his present home due to difficulties with neighbours and local drug dealers. Advised that I would discuss same with Dr Cavanagh. Leon is also wishing input from social work to apply for bankruptcy due to accumulating debts. Leon also informed me that his mother will collect him from Durness in two weeks time when his new account card from post office arrives. Advised Leon that I will contact his mother on 4/12/11.	ED Dyf
1655	Dr Cavanagh's meeting 29/12/11 - no changes	WJL Inter
30/12/11 1932	No change in presentation. Continues to pace corridor. Requested given PRN diclofenac sodium 50mg at 1845 hrs for headache and general body ache.	RM mibq
31/12/11 06:20	(NR) Has been awake for much of the night. Spending short periods at bed area and most of the night in sitting room/courtyard. Continues to complain of various aches and pains	KSing
12:30	Remained in bed all morning refusing to attend to ADL's	De
19:50	Leon was in his bed until his evening meal arrived he refused his meal, he has paced up the corridor at a fast pace. At one point he made a very loud shout from the music room, when staff approached he said he was yawning, no concerns to report	SBen
1/1/12 06:15	(NR) Requested and given Diclofenac sodium 50mg at 22:40 hrs for various aches and pains. Slept long spells although awake at times. Laughing inappropriately on occasions	KSing