

F515383.

GRATTON, LEON
85 Spittalfield Rd
Inverkeithing
KY11 1DZ

CHI: 170375119
D.O.B. 17/03/1971

21/12/09

Voices - sparrows

Hears hear "magazine" - but

for hours, bright lights, sitting on

Oak, eyes but + $\times 1/2$ per night

at least

weeks $\times 4$ weeks - inside +

outside to bed, sitting, as if

some doubts in between -

about birds at home

a 1 yr old on with it? - now

Devised

been busy - has a job

c/o law road -

His cat at = park by the

road it was -

Tried at abraham 20y past

18/8/10 DNA

Surname GRATTON

First Names LEON

Maiden Surname

Address

Unit No.

Date seen or Admitted 25/04/08

Seen at Wnd 2

Seen by *Leon*

Consultant in Charge *M*

Family Dr.

Referred by

D. of B.

Sex M. F.

M.S.W.D.

Religion

Occupation

PRESENTING COMPLAINT

DETAINED YES/NO

- Referred by CAHT.
- Moved them today ~~about~~ that he was going to take an overdose of valium (Dianepam) unknown quantity + Paracetamol + Slimming tablets with Bleach.
- Denies taking anything currently.

HISTORY OF PRESENTING COMPLAINT

- has been unwell for 6-8 weeks.
- Says he has been anxious and screaming at his flat at night time.
- No hearing voices at times. usually hears many different voices. Red intensity 1-2 weeks. Voices tell him that he is a dog and a deformed species.
- No sleep for last 4-6 weeks. gets sleep in day cause he is paranoid & frightened at nights.
- His neighbours are very noisy and have been aggressive towards him.
- He told community team that he felt like killing his neighbour today.
- He called community team twice threatening to take an overdose.
- had his depot today.
- No poor appetite. No weight loss.
- Thinking of taking an overdose of Bleach, Paracetamol & Slimming tablets.

PAST PSYCHIATRIC HISTORY

- Paranoid Schizophrenia
- Borderline Personality Disorder

FAMILY PSYCHIATRIC HISTORY

PAST MEDICAL HISTORY

- Eczema
- Asthma

CURRENT MEDICATION

(including allergies, herbal medication, homeopathic remedies and other self-medication)

- Clopixol 100mg / weekly

PERSONAL HISTORY

Born in Manchester. Moved to Edinburgh since he was 2.
Know to 4 Services.

SOCIAL HISTORY

(including social work input, finances, forensic, drugs)

currently lives alone.
doesn't work
gets DLA & income supports
Single. 1 child. No contact

MENTAL STATE EXAMINATION

(including appearance, behaviour, speech, mood suicidality, thoughts, perceptions, insight, cognitive function)

- 33 year old slightly unkempt, unshaven gentleman.
- Good eye contact. Normal speech.
- No evidence of ~~psychomotor~~ psychomotor agitation/retardation.
- Mood (O) Depressed
(S) slightly low with a reactive affect.
- Planning to take an overdose of bleach, paracetamol and timing tablets.
- Thinking about killing his neighbour because he thinks he is a dog.
- No hearing voices at night mainly. No subjective evidence of responding to external stimuli currently.
- No evidence of FTD. Oriented in place & person.

Little insight to his circumstances.

SUMMARY

(including formulation, diagnosis and differential diagnoses)

- 33 year old gentleman with $\frac{1}{2}$ of Paranoid Schizophrenia becoming unwell recently.
- Threatening to take an overdose as he is tired of his circumstances also threatening to kill his neighbours because they are bothering him.

TREATMENT PLAN

(including observation status)

- Admit to hospital ~~with~~ because of significant risk of self harm.
- Assessment of mental state in hospital.
- Risk assessment by team.
- Physical & bloods tomorrow.


Name of Admitting Doctor


Signature

28/4/8

UR Dr Cavanagh

Hx of schizophrenia

0133 412326

- Admitted to hearing voices / suicidal thoughts.
- Social circumstances re: mum possibly abused grandeur - has been stressed
- Insomnia. Worrying during the day.
- ↑ depot $\approx$ 2/52 ago: feels it has helped. Feels calmer (Thursday).
- Voices have improved since admission.

①) 2/7 more days in need to renew mental state

2) Passes: 4hrs. if need to ① to get clothes.

Dr Cavanagh (SR2)

29/4/8

UR Dr

ATS Doctor - wanting to go ①

- ① Voices - Remains. Has heard voices on a daily basis since he was 21y. Some parts of day - voices recede, particularly when distracted. Numerous voices: talking to him $\rightarrow$ saying derogatory / scandalous things to him about him. All male voices. Voices still present but not as distressed by comments.
- ② Suicidal ideation - Has thoughts every so often, but does not plan or think that he will act on his thoughts. Thoughts minimal today. His son stops him from carrying out acts of self harm.

- ③ Has no homicidal ideation. If neighbor disturbs him - he will call police.

MRE ①: Casually dressed. Moderately kempt

② Appropriate. Polite. Good eye contact

M - 0 + 5 - ①

MRE - No ψ motor retardation / No abn @ movements

Thoughts - as above. Wants to go home. Feels better. Finds need cold

Percept - as above

Suicide / Homicide - as above.

Body - Feels better. Anore feels better / less distressed.

①) DIC today to Richmond F&M (Mon / Tue / Wed / Fri / Sat)

②) UFGT 3x / week ③) Dr Cavanagh ④) Cavanagh Clinic (Ceph)

DEAR DOCTOR,

8/6/8

EDN GRATON, 17/3/75

THANK YOU FOR RECEIVING THE TRANSFER OF
THIS 33 YR OLD MAN KNOWN TO DR CARBONELL
W/ HX OF SCHIZOPHRENIA.

HE TOOK OUTDOSE OF ~ 16 PARALANAL 500mg TABS
@ 11³⁰ AM TODAY ON 8/6/8. NOW MEDICALLY FIT

FROM WD-8. PATIENT HAS CONTINUING

SUICIDAL IDEATION AT PRESENT + LOW MOOD.

PAST OD'S /OSIT.

DUE TO ↑ RISK I FEE HE WOULD BENEFIT FROM
CRISIS ADMISSION - UNFORTUNATELY NO BEDS IN
(more)
WD 2 QMHT.

TAKES CLOPIXOL DEPOT ON TUESDAYS - ? DOSE

- NO NOTES LOCATED AND WFOOT UNAVAILABLE TO
DISCERN DOSE - WOULD NEED TO CONTACT THEM MORE.

THANK YOU FOR YOUR HELP.

 (DR CHEW
ONLY) SHO (2293)

NAME LEON GRATION

Continuation Sheet No.

Unit No.

3/6/8

5:30 PM

F5153833 DOB = 17/3/75 85 SPINR RO
INVESTIGATORDR GARMONY
FELONY CT, INVERPUGH
MEDICAL
CENTRE

SUB ON CALL FOR PSYCHIATRY — REFERRAL FROM MD 8 AMH.

33yr old man

UNFORTUNATELY

* NOTES NOT
LOCATEDPARACETAMOL
OVERDOSE

— KNOWN TO DR CHANDLER

— Hx OF SCHIZOPHRENIA

— HFCOT NOT CONSENTED
WITH LAST MD MEETING
IN MAY 08.

PC:

HPC:

— PARACETAMOL OVERDOSE @ ~ 11:30am ON 8/6/8
OF ~ 16 TABLETS OF PARACETAMOL.

— 'LONGER, DEPRESSIVE, SUICIDAL' — 'LONG TIME'

— LOW YESTERDAY — SUICIDAL THOUGHTS BUT
'DISTURBED THEM'

— YEARS.

— VARIES.

— LOW FOR ~ 1 YR.

— TODAY

— LISTENING TO MUSIC — 0 FEEL 'BLOCK' 'TIRED'

— TOOK TABLETS — BOUGHT 16 PARACETAMOLS FROM SHOP

— WENT HOME, ALONE, TOOK TABLETS — 0 PANIC

— PHONE SOMEONE / ALONE ~~ALONE~~— FATHER PHONO ~~ALONE~~ AMBULANCE — POWER DIED THEN
WAS HE'D DONE — 0 ATT.

— 'HOPING TO DIE', THOUGHT IT WOULD WORK.

— 0 PLAN 0 SUICIDE NOTE 0 PLANS IN PLACE IF DIED.

— 'STILL WANTS TO DIE' 0 ALCOHOL / DRUGS TODAY / YESTERDAY

— COMMENTS TO SOME SUICIDAL IDEAS — ? SPECIFIC IDEAS / PLANS

— MOOD = 'DEPRESSIVE' 'SUICIDAL' — YRS — MOOD WOULD BE DOWN
GOES ON BUT VARIES— SUFFER — 'UP + DOWN' — OK REPUTATION.
NOT GOOD, WOULD NOT— CAN'T REMEMBER LAST
LAST FEEL GOOD

— SPENDS TIME READING / WRITING — ENJOYS — ENJOYS TOO

MS878 — SELF CARE GOOD, APPARENT GOOD; INTEREST NOT LOST — 25% IN
STUDY

- 77 3997 2293 8191 8194
- ENERGY VOICES - V. DROPS AT PRESENT
 - OFFERS / FORM TO SUPPORT - GRS SUPPORT FROM RICHARD KOBRODIT
 - 'DON'T CARE ABOUT FUTURE' '2 BULL'
 - THINKS 'HE'S A SCUMBAG' - ↓ SELF WORTH.
 - DROPS HOMICIDE IDEAS ° PROBLEMS WITH DAD
 - ° HALUCINATIONS - DROPS PSYCHOTIC SYMPTOMS

LAST PSYCH Vx.

- POST ADMISION TO WARD 2 IN PAST.
- LAST ADMISION TO WARD 2 - D/C 6/2/8
- SCHIZOPHRENIA - IN PAST FROM VOICES / NON COMPLIANT - MEDS DEBROWNOT
- W/FLOT - SAW LAST WK.
- MISSED LAST OP APPT 3 WKS AGO WITH DR CARPENTIER - MISSED, BUS
- OUTDOORS IN PAST - XMAS 08 - LAST TIME.
- ~~WAS~~ BATTLES BATTLES - 3 TO GO

MH
ECZEMA

- MEDS
- CLOPIXOL DEPOT - WKLY - LOST ON TUE
 - NIMAZEPAM 10mg NOCT.
 - DIAZEPAM 5mg NOCT. / PRN
- DEBROWNOT
- NKDA
 - NO SF'S
 - BREAST - ↓ VOICE

- +
- BROTHER - BIPOLAR DISORDER
 - MUM (? DUE) CONCERNED IN EDINBURGH IN FLIES - NOT IN CONTACT FOR FEW WKS.
 - DAD (56) - BUILDING SITE MANAGER - SFFS X1/YR - SFFMS X2/LA - LIVES IN MANCHESTER
 - SISTER X2 - (23 + 27) - NOT IN CONTACT FOR YRS.
 - ° PARTNER - SINGLE.
 - SON (9) - NOT IN CONTACT WITH DAD / MOTHER.

PERSONAL Hx.

- BORN IN MANABOR - 1st COMPLAINS
- GROWN UP W/ BORN PARENTS, EDINBURGH
- LIVED WITH MUM - @ 3 - SAVED SLEEPING - HAD LIVED WITH MUM
- DOES GET ON WITH HER - SISTER CONS. HER NAMED
- 1st SCHOOL IN W. HILLS 2nd - TRUBERT - LEFT SCHOOL @ 16 - 15 GRADE
- WORKED AS SLABBER IN EDINBURGH - 6 MONTHS - CANNABIS, LSD, GUE
- STOPPED DRUGS 2 YRS LATER - STARTED WORKING IN FISH, PARTIAL PICKING
- PSYCHO HISTORY

SH - LIVES ALONE IN COMMON HOUSE IN INVERNESS

- UNEMPLOYED - LAST WORKED AT BDA STAFFING 6 YRS AGO
- DLA + INCOME SUPPORT
- SMOKES 20/DAY

ALCOHOL - NON DRINKER - PROBABLY FRS @ XMAS 07, FEB 06

- ? ALCOHOL DRUG - 3 YRS AGO

DRUGS - NIL RECENT

- LAST DRUG 4 YRS
- CANNABIS - OCCASIONAL JOINT
- TRIPS COCAINE, AMPHETAMINE, LSD

FORENSIC Hx.

- ASSAULT - FINES
- SHOPLIFTING - FINES
- NO PRISON

MSF

- A+B - CASUALTY DRUGS CHARGE MUM, GOOD EC + REASONING
- S + IF - MONOTONE, @ r, r, ↓ VOL. °FTD.
- M 'depressed' 'suicidal' ○ low mood ↓ reactivity
- MS878 'cut' '1.0' 'louder' 'depressed' on

- P) - denies, nil aloud, not open response to hallucinations
- C) - grossly intact - oriented to T, P, P.
- E) - good insight - realises feels low in mood + ° psychiatric symptoms
 - willing to accept help + take meds
 - willing for admission
- D) - suicidal attempt - OD today - continues to have suicidal ideation? ^{specific} suicidal ideation ° plans.
 - denies homicidal ideation/plans

MP - 33 yr old man known to WD2 / DR GARDNER

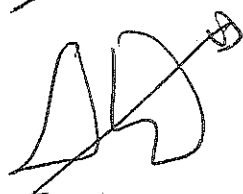
- Hx OF SCHIZOPHRENIA
- OVERDOSE OF ~ 16 PARACETAMOL 500mg TABS today
- LOW MOOD, DRUGS PSYCHIC SYMPTOMS
- CONTINUE TO FEAR 'SUICIDE' - POST ATTEMPT INC HANGING
- LIVES ALONE, LITTLE FAMILY / FRIENDS SUPPORT.
- DUE TO ↑ RISK, POST DSIT + SCHIZOPHRENIA.
- FEAR OF NEGOS CRISIS ADMISSION.

PLAN

- UNFORWARRD NO MORE DRS AT WD2, QMH.
- TRANSFER FROM WD 8 - & WOODBANK, KIRKBY
- INFORMED ADMISSION
- GENERAL OBS
- KANDOR
- o/e ✓ BLOODS (CONSIDER OUT IN WD 8 BE MHOUS) ✓
- MEDICS START MEDICATION FIT FOR D/C - OBS STABLE ✓
- DEPT OUT ON TUESDAY - MISSED LAST WK.
- ? DASH - NEED TO CHECK WITH WFOOT DR

- UNFORTUNATELY ABLE TO LOCATE HIS MOTHER.
- PRN SPOON.
- ASK MEDICAL STAFF TO R/V IF KNOWN FOR D/K FOR OPERATION.
- NOTE FBC - WCC = 13.8 - ? DUE TO OVERDOSE - MEDICS SUGGEST CO AMOXICILAV IF REMAINS ↑ WCC + SYMPTOMATIC.
- NO SIGNS OF INFECTION, OBS JABBLE NO P428PM
- MEDICS FEEL OK FOR D/K.

O/E:



RR = 15

O2 SAT = 100%
ON O2

CNS

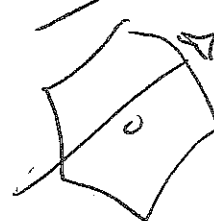
HS FETTER

O2 FETTER

BP = 125/70

HR = 75 REG.

LF



CMS

- GROSSLY
INJURED

(cont'd)
Smo/2200

DAD 0161 776 1420

08.06.08
2130Fyz Mclean (@ Whytemans Brae)
(on-call psychiatry)Bloods (on SCI):
from 8/6/8Hb 15.7
WCC 13.8 ↑
Neut 10.13 ↑
Plt 244

PT 11

APTT 34

Fib 3.4

Remainder of bloods not on SCI yet.

Up to date info since transfer;

Pt "fine"

Regarding suicidality "no point in here, can't do it in here". If went in WBH, "don't know" what he'd do. Denies active plans.

Pt. feels can stay over-night until R/V by a consultant (Dr. Smith) so can stay informal.

No additional issues. Pt. settled onto ward (currently ^{was} watching the football)

① R/V by Dr. Smith

ECG requested

Pls. chase remainder of bloods.

Will need confirmation of med's as requested by QNH SHO.

? Location of notes

pmc clear
(fyz)

9/6/18 Medical Review

Admitted yesterday

Longstanding D of schizophrenia.

— regular admissions to QNH

2 this year. Feb '08 for 2 1/2 yr post op

and readmitted "4 weeks ago" for 2 1/2

Used support:

OPA Dr. Connolly 4 1/2 hr (missed last)

CPN 1-2 x weekly. Dept Tuesday

Redmond Fellowship 6 x weekly

Last 4 1/2 low mood. Nil psychiatric

Tried to press charges against mother for abuse as child and concern over safety of his 9yo son (lives with ex father, mother has access, he does not)

No evidence of depression sleep app (sleep OK)

Imp

NO clear evidence of depression

Longstanding schizophrenia. Recent stress with mother

Ongoing suicidal ideation, no intent (plans)

Agrees to stay informally. Not detainable today

Await ambulance led → transfer to Dr. Smith

11/6/8

Admitted 4-5/7 ago to O/D of paracetamol

- 2/7 prior heard that charges against mum for sexual abuse against him & son were drops. Thoughts of this in head and thoughts of previous rape: felt had enough: Didn't want to live
→ Took paracetamol, then phoned Naidra / Dad. His dad phoned SAS - A+E.

Still feel 'suicidal' / Doesn't want to live. Has had suicidal thoughts since 6 yrs. old. No current plans but thinks 'would probably just take some tablets... sometimes I think of jumping off the bridge'.

Mood - low for a long time. Energy ok. Appetite ok sleeping well. Enjoys company of people. Feels lonely in community.

①) Observe on next day or two

2) R/U R. Cavenagh Friday → new to d/c?

Elneberry CST2

12/6/8

- Nursing Report - laughing loudly / inappropriately. Talking of mother
- Asked about mother - felt like school mothered 'matroso'. Felt last admission had a cut on throat.
- Hearing echos - on 'oooo' noise. Not heard screaming
- Feels safe on ward.
- Sleeping better

①) ~~2nd admission~~ ^{FV periboxed} Feels in view of ↑ ~~2nd admission~~ ^{Flight}

2) D/C to depot. clinic. reg closed down.

Elneberry CST2

16/6/09 Occasional
Sleeping OK.

Has been observed fairly
when alone - during
pleases. " what possible
screams - It's how is
is getting attacked" tide tank

Shows a female voice - in
the distance - couple of minutes -
its showed the idea before.
Smaller idea still happening.

16/6/08 Remains settled, intentions
well. Spending time on bed. Assessed
by Buchanan Fellowship for support
do here. Concerned about (see)
cables - no observed response to
yellants.
no evidence of road sides.
from express it did not a road

23/6/8

Had w/e pass - difficult: auditory hallucinations
 - "out side & in my head" - laughter.

Took extra Risperidol tablets on Saturday

- purpose of tablets - "stop the voices" → worked

Phoned Wad / Semantics over w/e - "someone to talk to"

During the day - slept. "As soon as I get back to that home..."

Thinking - "A couple of mins, I just about crawled up."

Suicidal ideation - "Wanted to go & do it"

① ↑ depot

2) Tom pass to Friday

3) Kadox for depot clinic

Releaborn (STZ)

24/6/8

U&Es - Na - 140 / K - 2.7 / U₁ - 5.1 / Creat - 100.

On pass full Friday

Releaborn (STZ)

27/6/8

Back from pass. Felt passes went well - felt well.

Didn't attend depot clinic yesterday - depot today.

Asking for d/c.

- ? with Richmond went to hearing support centre to
 look @ creative writing - seems keen.

- No further auditory hallucinations ° Paranoid - dragging.

- No thought of suicide / no plan / no attempted or
 temptation to O/D. Appears bright / no response / ° FTD.

① D/C to med (daily dosing)

2) Depot.

3) UACOT / Richmond F/U.

Releaborn (STZ)

Forename: <u>LEON</u>	Address: <u>85 SPITTFIELD RD</u>	DOB: <u>19/3/75</u>
Surname: <u>GRATTON</u>	<u>INVERKEITHING</u>	CHI No / Hospital No: <u>F 515 2433</u>

Medicines on Discharge

Medicine Form & Strength	Dose	Directions for Administration	Continuous/ Course Length	Quantity Supplied
<u>NITRAZEPAM</u>	<u>10mg</u>	<u>30AL / NIGHT</u>	<u>Cont</u>	<u>1/7 - 12/11</u>
<u>FLUPENTIXOL DECANATE</u>	<u>150mg</u>	<u>Weekly (Course)</u>		

Medication currently prescribed by Day Hospital: Yes ☐ No ☒

Dispense in Compliance Aid Yes ☐ No ☒

Type of compliance aid before admission:

Significant Changes to Medication from the Point of Admission

Medicine	Stopped/Started/ Changed	Details of Change and Reasons

Additional information attached: Warfarin sheet Yes ☐ No ☒ Other: Yes ☐ No ☒ Please specify:

Adverse Reactions/Allergies: Yes ☐ No ☒ Detail:

Comments:

Signature: [Signature] Date: 27/6/18

Name (in CAPS): INVERKEITHING

Contact No. for enquiries: 2298

Designation: Consultant/Registrar ☐ SHO ☒ JHO ☐ Other ☐

Clinically Checked
by Pharmacist: _____

Dispensed: _____

Check: _____

Date: _____

DATE OF ADMISSION:

8 / 6 / 2008

DATE OF DISCHARGE:

27 / 6 / 2008

IMMEDIATE DISCHARGE & PRESCRIPTION FORM

Hospital Site: 0111

Page1. of ...1...

(Please use BLOCK CAPS when completing this form)

Re: Mr/Mrs/Miss/Ms:	DOB: 17/12/75	TO: GP Forename: DL
Forename: LEON	Surname: GRAYTON	GP Surname: GRAYTON
Address: 53 SPITALFIELD RD.		GP Address: INVERLOCHNIE MIL
Postcode:		GP Postcode:
CHI No:	Hosp ID No: F513203	Community Pharmacy:

This patient was admitted to hospital under the care of:

Consultants Name: DL GRAYTON Specialty: PSYCHIATRY

Discharged from Ward: (2) Reason for Admission/presenting complaint: ACUTE PSYCHOSE / DD / SICKLE.

Mode of Admission: Elective ☐ Emergency ☐ Transfer ☒ Source of admission: GP ☐ Self ☐ Out of Hours ☒ Other: W/D

Principal Diagnosis: SCHIZOPHRENIA Legal Status: INFORMAL

Other Conditions:

1
2
3
4
5

Significant Operations/Procedures: Yes ☐ No ☒

1. Date:

2. Date:

Relevant Investigations: Yes ☐ No ☒ Comments:

Complications: Yes ☐ No ☒ Comments:

Patient Information discharge summary given to patient and/or carer or relative: Yes ☐ No ☒

Follow-up Arrangements

WFCOT
DL GRAYTON O/P.

Sickness Certificate Issued: Yes ☐ No ☒ Duration of sickness certification:
 Results awaited: Yes ☐ No ☒ If Yes, please specify:
 Letters to follow: Yes ☒ No ☐ Comment:
 Hospital Review: Yes ☒ No ☐ If Yes, please specify:

DATE OF ADMISSION:

01 / 02 / 08

DATE OF DISCHARGE:

05 / 02 / 08

IMMEDIATE DISCHARGE & PRESCRIPTION FORM

Hospital Site: QMHT

Page ... of ...

(Please use BLOCK CAPS when completing this form)

Re: Mr/Mrs/Miss/Ms	DOB: 17/03/78	TO: GP Forename: D.
Forename: LEON	Surname: GRANTON	GP Surname: GARMAN
Address: 25 SPINFIELD		GP Address: 11 BURNHILL MEDICAL
WINDHILL		CENTRE, 5 FRIMLEY COURT
Postcode: KY11 1DZ		GP Postcode: KY11 1DZ
CHI No: 17037119	Hosp ID No:	Community Pharmacy:

This patient was admitted to hospital under the care of:

Consultant's Name: CAHANAGH Specialty: PSYCHIATRY

Discharged from Ward: 2 Reason for Admission/presenting complaint: PSYCHOLOGICAL CRISIS

Mode of Admission: Elective ☒ Emergency ☐ Transfer ☐ Source of admission: GP ☐ Self ☐ Out of Hours ☐ Other:

Principal Diagnosis: SCHIZOPHRENIA Legal Status: INFORMAL

Other Conditions:

1	SUBSTANCE PERUSALITY DISORDER
2	
3	
4	
5	

Significant Operations/Procedures: Yes ☐ No ☒

1. Date:

2. Date:

Relevant Investigations: Yes ☐ No ☒ Comments:

Complications: Yes ☐ No ☒ Comments:

Patient Information discharge summary given to patient and/or carer or relative: Yes ☐ No ☐

Follow-up Arrangements

WFCOT

UPD

Psychological therapy

Sickness Certificate Issued: Yes ☐ No ☒ Duration of sickness certification:

Results awaited: Yes ☐ No ☒ If Yes, please specify:

Letters to follow: Yes ☐ No ☒ Comment: DISCHARGE SUMMARY

Hospital Review: Yes ☐ No ☒ If Yes, please specify:

Forename: <u>LEON</u>	Address: <u>ST SPITALFIELD</u>	DOB: <u>11/01/75</u>
Surname: <u>GRATTON</u>	<u>INDERMEDICALS 2Y11 102</u>	CHI No / Hospital No: <u>11035114</u>

Medicines on Discharge

Medicine Form & Strength	Dose	Directions for Administration	Continuous/ Course Length	Quantity Supplied
<u>NITRAZEPAM</u>	<u>10mg</u>	<u>ORAL ONCE</u>	<u>7/7</u>	<u>7/7</u>
<u>DIAZEPAM</u>	<u>5mg</u>	<u>ORAL ONCE</u>	<u>Cont.</u>	<u>7/7</u>
<u>FLURIDEPAN 10mg</u>	<u>10mg</u>	<u>1m weekly</u>	<u>Cont.</u>	<u>DERILLUM</u>

Medication currently prescribed by Day Hospital: Yes ☐ No ☒

Dispense in Compliance Aid Yes ☐ No ☒

Type of compliance aid before admission:

Significant Changes to Medication from the Point of Admission

Medicine	Stopped/Started/ Changed	Details of Change and Reasons
<u>DEPT INCLINIC</u>		

Additional information attached: Warfarin sheet Yes ☐ No ☒ Other: Yes ☐ No ☐ Please specify:

Adverse Reactions/Allergies: Yes ☐ No ☒ Detail:

Comments:

Signature: [Signature] Date: 09/02/28
 Name (in CAPS): MANU ADRIAN
 Contact No. for enquiries: 2298
 Designation: Consultant/Registrar ☐ SHO ☒ JHO ☐ Other ☐

Clinically Checked
by Pharmacist: [Signature]
 Dispensed: [Signature]
 Check: [Signature]
 Date: [Signature]

$$\sqrt{5 \times 8} \quad (53)$$

Medicines on Discharge

Medicine Form & Strength	Dose	Directions for Administration	Continuous/ Course Length	Quantity Supplied
ENCLOMANTHINE PILLS		100mg	7 days	
ENCLOMANTHINE PILL	100mg	100mg	7 days	
NITRAZEPAM	10mg	10mg	19 days	
VIALETTA	5mg	5mg	7 days	

Medication currently prescribed by Day Hospital: Yes ☐ No ☒

Dispense in Compliance Aid Yes ☐ No ☒

Type of compliance aid before admission:

Significant Changes to Medication from the Point of Admission

[illegible]

Additional information attached: Warfarin sheet Yes ☐ No ☐ **Other:** Yes ☐ No ☐ Please specify:

Adverse Reactions/Allergies: Yes ☐ No ☐ Detail: _____

Comments:

Signature: _____ Date: 25/11/20

Name (in CAPS): JOHN MICHAEL WILSON

Contact No. for enquiries: 2214

Designation: Consultant/Registrar ☐ SHO ☒ JHO ☐ Other ☐

Clinically Checked
by Pharmacist:

Dispensed:

Check:

Date:

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

MEDICINE RECORDING SHEET

KEY
A DRUG REFUSED
X PATIENT ABSENT

Date	REGULAR PRESCRIPTIONS												DEPOT INJECTION				AS REQUIRED				COMMENTS ON DISCREPANCIES
	OTHER TIMES												Code				Code				
	8.00	13.00	18.00	Intls	22.00	Intls	Code	Time	Intls	Code	Time	Intls	Code	Time	Intls	Code	Time	Intls			
18/12/08																				L DUE 23.12.08	
23/12/08																				R DUE 30-12-8	
30/10/08																				cf 6.01.09	
31/12/8																				cf 7-1-9	
8/1/09																				cf 13.01.09	
13/1/9																				R DUE 20/1/9	
20/1/9																				L DUE 27/1/9	
27/1/9																				R DUE 3-2-9	
3/2/9																				L DUE 10-2-9	
10/2/09																				R DUE 14.2.09	
17/2/09																				L DUE 24.2.09	
24/2/09																				R DUE 03-03-09	
7/3/09																				cf 5.3.09	
5/3/9																				cf 10-3-9	

NAME: L2010 GRATTON UNIT No: FSLS3833 WARD: CARPAGIE CLINIC

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

KEY
ⓐ DRUG REFUSED
ⓑ PATIENT ABSENT

MEDICINE RECORDING SHEET

Date	REGULAR PRESCRIPTIONS						OTHER TIMES						DEPOT INJECTION			AS REQUIRED			COMMENTS ON DISCREPANCIES		
	8.00	Ints	13.00	Ints	18.00	Ints	22.00	Ints	Code	Time	Ints	Code	Time	Ints	Code	Time	Ints	Code		Time	Ints
19/3/09																					L 14.30g
24/3/09																					ⓐ 24-3-9
31/3/09																					ⓐ 31/3/09
7/4/09																					L 21/4/09
14/4/09																					L 28-4-09
21/4/09																					ⓐ 5-5-9
28/4/09																					ⓐ 12-5-9
5/5/09																					CP 14-5-09
12/5/09																					CP 19-5-9
19/5/09																					ⓐ 26.50g
26/5/09																					CP 28.5.05
1/6/09																					

NAME: LEON CRATTON UNIT No: F5153833 WARD:

REGULAR PRESCRIPTIONS

AS REQUIRED

COMMENTS ON
DISCREPANCIES

OTHER TIMES

INJECTION

COMMENTS ON
DISCREPANCIES

1/5	80°C
-----	------

14	8/5/71
----	--------

(MR) 57

KEY
☐ A DRUG REFUSED
☒ A PATIENT ABSENT

MEDICINE RECORDING SHEET

[illegible]

	KEY
(A)	DRUG REFUSED
(X)	PATIENT ABSENT

MEDICINE RECORDING SHEET

[illegible]

NAME: Leon Gratton UNIT No: F5153833 WARD: Carnegie Clinic

Sheet No. 2 of 2.

WARD 2

PREScription SHEET (USE BLOCK LETTERS)

Sheet No. 1 of 2.

START DATE	DISCONTINUED		REGULAR MEDICINES	DOSE	METHOD OF ADMINISTRATION	TIME OF ADMINISTRATION					PRESCRIBER'S SIGNATURE	
	Date	Signature				0800	1300	1800	2200	Other times		
A												
B												
C												
D												
E												
F												
G												
H												
I												
J												
K												
L												
M												
N												
O												
P												
START DATE	DISCONTINUED		AS REQUIRED MEDICINES	DOSE	METHOD OF ADMINISTRATION	INDICATION	MAXIMUM FREQUENCY	PRESCRIBER'S SIGNATURE				
26/4/18			NITRAZEPAM	10mg	oral	Insomnia	once only at night					
27/4/18			Symptomatic relief	as per protocol								
28/4/18			LOXAZEPAM	2mg	oral	anxiety	4mg in 240					
29/4/18			LOXAZEPAM	2mg	oral	anxiety	4mg in 240					
W												
X												
Y												
Z												
START DATE	DISCONTINUED		DEPOT INJECTIONS	DOSE	FREQUENCY	PRESCRIBER'S SIGNATURE	TICK IF PRESCRIBED ON THE FOLLOWING SHEET	LIST OF MEDICINES TO BE AVOIDED DUE TO PREVIOUS REACTION	PRESCRIBER'S SIGNATURE			
1							✓					
2												
3												
4												

ONCE ONLY MEDICINES AND PREMEDICATION				
DATE	MEDICINE	DOSE	METHOD OF ADMINISTRATION	TIME
26/4/18	Diazepam	5mg	oral	18:30
27/4/18	gabapentin	10mg	oral	19:00
28/4/18	DIAZEPAM	5mg	oral	19:00

DATE	MEDICINE	DOSE	METHOD OF ADMINISTRATION	TIME	PRESCRIBER'S SIGNATURE	GIVEN BY	GIVEN AT
26/4/18	Diazepam	5mg	oral	18:30		18 SA	18:35
27/4/18	gabapentin	10mg	oral	19:00			
28/4/18	DIAZEPAM	5mg	oral	19:00		18 SA	20:35

PRESCRIPTION SHEET (USE BLOCK LETTERS)

Sheet No. 1

START DATE	DISCONTINUED		REGULAR MEDICINES	DOSE	METHOD OF ADMINISTRATION	TIME OF ADMINISTRATION					PRESCRIBER'S SIGNATURE	
	Date	Signature				0800	1300	1800	2200	Other times		
A 8/6/8			NIGERAZEPAM	10mg	ORAL							
B 13/6/8			Zodopentol	10mg								
C 13/6/8			Flupentixol decanoate	10mg								
D 13/6/8			Flupentixol decanoate	4mg								
E 13/6/8			CLOTRIMAZOLE 1% cream	1 applicator	topical - penis							
F 14/06/08			FLUPENTIXOL DIHYDROCHLORIDE	3mg	ORAL							
G												
H												
I												
J												
K												
L												
M												
N												
O												
P												

START DATE	DISCONTINUED		AS REQUIRED MEDICINES	DOSE	METHOD OF ADMINISTRATION	INDICATION	MAXIMUM FREQUENCY	PRESCRIBER'S SIGNATURE
	Date	Signature						
R 8/6/8			Symptomatic relief of PRP	1-2mg	ORAL	anxiety	2mg/24hrs - 1mg	
S 8/6/8			LOXAPROPRAM	1-2mg	IM	anxiety	1mg/24hrs - 1mg	
T 8/6/8			LOXAPROPRAM	1-2mg	ORAL	anxiety	once in 24hrs	
U 8/6/8			CHLORPROMAZINE	5mg	ORAL	anxiety	4mg by mouth 34hrs/24hrs	
V 8/6/8			PROYCLIDINE	5mg	ORAL	anxiety	6mg by mouth 34hrs/24hrs	
W 8/6/8			ELYSUM	1appls	topical	anxiety	6mg by mouth 34hrs/24hrs	
X 8/6/8			LOXAPROPRAM	1-2mg	IM	anxiety	4mg by mouth 34hrs/24hrs	

START DATE	DISCONTINUED		DEPOT INJECTIONS	DOSE	FREQUENCY	PRESCRIBER'S SIGNATURE	TICK IF PRESCRIBED ON THE FOLLOWING SHEET	LIST OF MEDICINES TO BE AVOIDED DUE TO PREVIOUS REACTION	MEDICINE	REFERRED DATE
	Date	Signature								
1 8/6/8			Flupentixol decanoate	100mg	weekly					
2 13/6/8			Flupentixol decanoate	100mg	weekly					
3 23.6.08			Flupentixol decanoate	150mg	weekly					

ONCE ONLY MEDICINES AND PREMEDICATION					
DATE	MEDICINE	DOSE	METHOD OF ADMINISTRATION	TIME	PRESCRIBER'S SIGNATURE
13/6/8	Zodopentol	10mg	IM	10:00	
13/6/8	Flupentixol decanoate	100mg	IM	10:00	
13.6.08	FLUPENTIXOL DIHYDROCHLORIDE	3mg	ORAL	20:00	

NAME OF PATIENT	AGE	DATE OF BIRTH	UNIT No.	CONSULTANT	WARD
1 DANIEL ANTON	22	17/2/20	FC-153822	DR CHANDRASEKAR	WARD WOODMAN

PRESCRIPTION SHEET (USE BLOCK LETTERS)

Sheet No.

START DATE	DISCONTINUED		REGULAR MEDICINES	DOSE	METHOD OF ADMINISTRATION	TIME OF ADMINISTRATION					PRESCRIBER'S SIGNATURE	
	Date	Signature				0800	1300	1800	2200	Other times		
A 01/02/08			WITAZEPAM	10mg	ORAL							
B 01/02/08			PARALAM	10mg	ORAL							
C 4/12/08			Diazepam	6mg	ORAL							
D												
E												
F												
G												
H												
I												
J												
K												
L												
M												
N												
O												
P												
START DATE	DISCONTINUED		AS REQUIRED MEDICINES		DOSE	METHOD OF ADMINISTRATION	INDICATION	MAXIMUM FREQUENCY	PRESCRIBER'S SIGNATURE			
Date	Signature	Date	Signature									
R 01/02/08			Symptomatic relief of Paroxysmal Concept		1mg	ORAL	AGITATION	MAX 4mg/24h				
S 01/02/08			LOXALAM		1mg	ORAL	AGITATION	MAX 2mg/24h				
T 01/02/08			LOXALAM		5mg	ORAL	AGITATION	MAX 30mg/24h				
U 01/02/08			LOXALAM		5mg	ORAL	AGITATION	MAX 15mg/24h				
V 2/12/18			IBUPROFEN with food		400mg	ORAL	Pain	MAX TDS 8 hourly rather than 12 hourly				
W												
X												
Y												
Z												
START DATE	DISCONTINUED		DEPOT INJECTIONS		DOSE	FREQUENCY	PRESCRIBER'S SIGNATURE	LIST OF MEDICINES TO BE AVOIDED DUE TO PREVIOUS REACTION				
Date	Signature	Date	Signature	TICK IF PRESCRIBED ON THE FOLLOWING SHEET				MEDICINE	REREFERRED DATE			
1 01/02/08			FLUPRENEXOL DECANOATE		50mg	WEEKLY						
2 01/02/08			FLUPRENEXOL DECANOATE		100mg	WEEKLY						
3												
4												

ONCE ONLY MEDICINES AND PREMEDICATION

DATE	MEDICINE	DOSE	METHOD OF ADMINISTRATION	TIME	PRESCRIBER'S SIGNATURE	GIVEN BY	GIVEN AT

NAME OF PATIENT

LEON GRATTON

AGE

DATE OF BIRTH

UNIT No.

FS/S 3853

Dr CAULFIELD

WARD 2
FHB(MR) 58

PRESCRIPTION SHEET (USE BLOCK LETTERS)

Sheet No.

START DATE	DISCONTINUED		REGULAR MEDICINES	DOSE	METHOD OF ADMINISTRATION	TIME OF ADMINISTRATION					PRESCRIBER'S SIGNATURE	
	Date	Signature				0800	1300	1800	2200	Other times		
A												
B												
C												
D												
E												
F												
G												
H												
I												
J												
K												
L												
M												
N												
O												
P												
START DATE	DISCONTINUED		AS REQUIRED MEDICINES	DOSE	METHOD OF ADMINISTRATION	INDICATION	MAXIMUM FREQUENCY	PRESCRIBER'S SIGNATURE				
Date	Signature	Date							Signature			
R												
S												
T												
U												
V												
W												
X												
Y												
Z												
START DATE	DISCONTINUED		DEPOT INJECTIONS	DOSE	FREQUENCY	PRESCRIBER'S SIGNATURE	TICK IF PRESCRIBED ON THE FOLLOWING SHEET	LIST OF MEDICINES TO BE AVOIDED DUE TO PREVIOUS REACTION		REREFERRED DATE		
Date	Signature	Date						Signature	MEDICINE		DATE	
1	08/02/68		FLUPENTIXOL DECANATE	100 mg	WEEKLY		✓					
2												
3												
4												

NAME OF PATIENT	AGE	DATE OF BIRTH	UNIT No	CONSULTANT	WARD CLINIC	FHB(MR) 58
LEON GRATTAN		17/08/75	FS153833A	CANMAGH	DEPT	

MEDICINE RECORDING SHEET

[illegible]

NAME: LEON SUTTON

UNIT No: F5153833

WARD: Z

KEY
 (A) DRUG REFUSED
 (A) PATIENT ABSENT

MEDICINE REC., DING SHEET

REGULAR PRESCRIPTIONS

INJECTION

AS REQUIRED

COMMENTS ON
DISCREPANCIES

Date	OTHER TIMES									
	8.00	Intls	13.00	Intls	18.00	Intls	22.00	Intls	Code	Time
8/6/08										
9/6/08										
10/6/08										
11/6/08										
12/6/08										
13/6/08										
14/6/08										
15/6/08										
16/6/08										
17/6/08										
18/6/08										
19/6/08										
20/6/08										

WOODS BANK

2-34

WOODS BANK

Woodstock

KEY
 (A) DRUG REFUSED
 (A) PATIENT ABSENT

MEDICINE RECORDING SHEET

REGULAR PRESCRIPTIONS

DATE: _____

DEPOT
INJECTION

AS REQUIRED

COMMENTS ON
DISCREPANCIES[illegible]

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

KEY
A DRUG REFUSED
X PATIENT ABSENT

MEDICINE RECORDING SHEET

MEDICINE RECORDING SHEET																							
PATIENT ABSENT																							
REGULAR PRESCRIPTIONS										DEPOT INJECTION				AS REQUIRED				COMMENTS ON DISCREPANCIES					
Date	8.00		13.00		18.00		22.00		OTHER TIMES		Code		Time		Code		Time		Code		Time		Intls
	Intls	Code	Intls	Code	Intls	Code	Intls	Code	Intls	Code	Intls	Code	Intls	Code	Intls	Code	Intls	Code	Intls	Code			
1/02/08																							
2/02/08																							
3/02/08																							
4/02/08																							
5/02/08																							

NAME: Leaw Gratton UNIT No: F515 WARD: Two
D.O.B: 17/03/75 Dr. C. W. Angell
(MR) 57

KEY
 (A) DRUG REFUSED
 (A) PATIENT ABSENT

DEPOT INJECTION	
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DEPOT
INJECTIONUNIT No.:

WARD:

Mental Health Directorate
ADMISSION INFORMATION SHEET [A1-1]

NHS

Initial admission to Ward/Department: 2 (Two)	Community Service/Hospital: QMH	Date 8/9/11 Time 16.10
Consultant: Lavanaga	Named Nurse/Case Manager Jean Liz Isobel	Unit No/CHI No 1703751191 F 515 3855 Care Programme Approach No

Personal Information

FULL NAME: Mr / Mrs / Ms / Miss / Master Leon Gratton	Where appropriate, likes to be known as: Leon	Previous or Maiden Name(s) N/A
	Date of Birth 17/3/75	Place of Birth Manchester
Home Address 5 Spitalfield Road Inverkeithing	Current Address AS Before	Marital Status Single
Post Code	Post Code	Telephone No(s) 079 22 564 97
Present/Past Occupation Unemployed	Religion and/or Chaplaincy requirement None	Ethnic Origin White English Sensory Impairment problem (s) None
Allergies None Known	Is English first language? Yes ☒ No ☐ Preferred Language	Is an interpreter required? Yes ☐ No ☒ Name (relationship to client, if any)
MHA Status Inf	Review Date	Patient Informed of Status By: Date:
Clinical Risk Yes ☒ No ☐ If yes; Specify Main Risk		Does the Adults with Incapacity Act Apply; Yes ☐ No ☒
Refer to Care Plan No _____		Is there an Identified Relapse Signature? Yes ☐ No ☒ If Yes; Refer to Care Plan No _____

Main Carer/Partner/Relatives/Named Person Information etc

(1) Full Name Mrs Lorna Gratton	Home Address Unknown	Telephone No. 07762 602112
	Post Code	Relationship Mother
(2) Full Name Mr Gary Gratton	Home address 57 Orchard Brae Manchester	Telephone No 0161 746 1420
	Post Code	Relationship Father
Does service user agree with the sharing of information with Carer / Nearest Relative /Partner Yes ☐ No ☐	Identify person to be contacted if patient is sick, dying or in any emergency.	Where appropriate - Order of Contact

Mental Health Directorate
ADMISSION INFORMATION SHEET [A1-1]

Patients Name Leon Grafton Unit/CHI No FS153833
1703751191

Diagnosis

Relevant Medical Condition:

Schizophrenia
BPD
ECZEMA
Asthma

Medication Concordance:

As Per Kardex

Community Service Involvement

	Name/Address	Tel No's
LMHT/Community Team	Dawn Stanley c/o Haldane House	01383 482 725
General Practitioner	Dr Garmay - Inverkeithing Med Practice	01383 413 234
Social Worker	Hona Hunter	01383 441 77
Community Psychiatric Nurse		
District Nurse		
Care Programme Approach Co-ordinator		
Home Care Manager		
Chaplain		
Dependants		
Other involvement	Dave Chaplin	01383 622 133
Richmond		

Patient Financial Information etc

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

Nursing Observations

Temperature	36.3	Pulse	115	Blood Pressure	117/76
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Signature of Person Completing this Form:

BL

Date: 8/9/11

Mental Health Directorate
ADMISSION INFORMATION SHEET [AI-1]

MHS

Initial admission to Ward/Department:	Community Service/Hospital:	Date Time
Consultant: DR CAVANAGH	Named Nurse/Case Manager DAWN STANLEY	Unit No/CHI No 1703751191. F5153833 Care Programme Approach No 194 DISCHARGED -

Personal Information

FULL NAME: Mr / Mrs / Ms / Miss / Master LEON GRATTON		Where appropriate, likes to be known as: LEON	Previous or Maiden Name(s)			
Date of Birth 17-03-75		Place of Birth MANCHESTER.				
Gender MALE		Marital Status				
Home Address 5 SPITALFIELD ROAD OVERLEITHING	Current Address	Telephone No(s) 079 22956457 0787 191 1072				
Post Code	Post Code	Ethnic Origin WHITE				
Present/Past Occupation UNEMPLOYED	Religion and/or Chaplaincy requirement NONE	Sensory Impairment problem (s) NONE				
Allergies NONE KNOWN		Is English first language? Yes ☒ No ☐ Preferred Language	Is an Interpreter required? Yes ☐ No ☒ Name (relationship to client, if any)			
MHA Status	Review Date	Patient Informed of Status By:	Clinical Risk Yes ☒ No ☐ If yes; Specify Main Risk SEE RISK ASSESSMENT.	Does the Adults with Incapacity Act Apply; Yes ☐ No ☒	Is there an Identified Relapse Signature? Yes ☐ No ☒	If Yes; Refer to Care Plan No _____
IF		Date:	Refer to Care Plan No _____			

Main Carer/Partner/Relatives/Named Person Information etc

(1) Full Name MRS LORNA GRATTON	Home Address Post Code	Telephone No. 07762 602112 Relationship MOTHER
(2) Full Name MR GARY GRATTON	Home address 57 ORCHARD BRAE MANCHESTER Post Code	Telephone No 0161 776 1420 Relationship
Does service user agree with the sharing of information with Carer / Nearest Relative /Partner Yes ☐ No ☒	Identify person to be contacted if patient is sick, dying or in any emergency.	Where appropriate - Order of Contact

No information to be given to Leon's mother - 27/6/10
 No information to Leon's mother - 5-4-11

Mental Health Directorate
ADMISSION INFORMATION SHEET [A1-1]

Patients Name LEON GRATTON Unit/CHI No F5153833

Diagnosis

Relevant Medical Condition:

SCHIZOPHRENIA.

BPD.

ECZEMA

ASTHMA

Medication Concordance:

Collects oral meds daily from pharmacy
Flupentixol 150mgs 1/52 - engages
reasonably well - attends depot clinic
with prompt.

Community Service Involvement

	Name/Address	Tel No's
LMHT/Community Team	Dawn Stanley % Haldane House	01383 432 725
General Practitioner	DR GARMANY - INVERKEITHING MEDICAL PRACTICE	01383 413 234
Social Worker		
Community Psychiatric Nurse		
District Nurse		
Care Programme Approach Co-ordinator		
Home Care Manager		
Chaplain		
Dependants		
Other involvement		
RICHMOND	DAVE CHARLIN.	01383 622 133

Financial Information etc

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

Nursing Observations

Temperature	Pulse	Blood Pressure
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Signature of Person Completing this Form: D. Stanley

Date: 14-3-10

Mental Health Directorate
ADMISSION INFORMATION SHEET [A1-1]



Initial admission to Ward/Department: 2.	Community Service/Hospital: Q.M.H.	Date of admission: 17/03/95 Time: 17.00hrs
Consultant: Dr CAVANAGH.	Named Nurse/Case Manager Arl Shirley Eddie.	Unit No/CHI No
		Care Programme Approach No

Personal Information

FULL NAME: ☒ Mr / ☐ Mrs / ☐ Ms / ☐ Miss / ☐ Master Leon Gratton.		Where appropriate, likes to be known as: Leon.	Previous or Maiden Name(s)
Home Address 85 Spitalfield Rd Inverkerthing st Code		Date of Birth 17/03/95.	Place of Birth Manchester
		Gender male.	
Present/Past Occupation Unemployed.		Current Address	Marital Status
		Post Code	Telephone No(s) 415625 07516623988
Allergies None known.		Religion and/or Chaplaincy requirement	Ethnic Origin
		Sensory Impairment problem (s)	
MHA Status 1st.		Review Date	Patient Informed of Status By:
		Date:	
Clinical Risk Yes ☒ No ☐ If yes; Specify Main Risk Physical aggression when unwell or under influence of alcohol/drugs.		Does the Adults with Incapacity Act Apply; Yes ☐ No ☒	
		Is there an Identified Relapse Signature? Yes ☐ No ☒ If Yes; Refer to Care Plan No _____	
Refer to Care Plan No _____		Refer to Care Plan No _____	

Main Carer/Partner/Relatives/Named Person Information etc

(1) Full Name Lorna Gratton	Home Address none given.	Telephone No. 07762602112
(2) Full Name	Post Code	Relationship mother.
	Home address	Telephone No
Does service user agree with the sharing of information with Carer / Nearest Relative / Partner Yes ☐ No ☒	Post Code	Relationship
	Identify person to be contacted if patient is sick, dying or in any emergency.	Where appropriate - Order of Contact

Mental Health Directorate
ADMISSION INFORMATION SHEET [A1-1]

Patients Name Leon Gratton Unit/CHI No

Diagnosis

Relevant Medical Condition:

Medication Concordance:

Community Service Involvement	Name/Address	Tel No's
LMHT/Community Team		
General Practitioner		
Social Worker		
Community Psychiatric Nurse	WFCOT - Tom Short	
District Nurse		
Care Programme Approach Co-ordinator		
Home Care Manager		
Chaplain		
Dependants		
Other involvement		

Patient Financial Information etc	Where appropriate - Name/Address	Tel No's
Welfare Power of Attorney:		
Power of Attorney/Guardian/Carator:		
Pension Book etc held by:		
House Keys held by:		
Insurance Number:		
Advanced Statement held at/with		

Nursing Observations

Temperature <u>36.2</u>	Pulse <u>72</u>	Blood Pressure <u>126/82</u>
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Signature of Person Completing this Form: A. M. M. M.

Date:

Mental Health Directorate
ADMISSION INFORMATION SHEET [A1-1]

NHS

Initial admission to Ward/Department: QMH	Community Service/Hospital: 2	Date 19/1/18 Time 11.55
Consultant: DR CAVANAGH	Named Nurse/Case Manager LINDA ANDY ISOBE	Unit No/CHI No FS153833
		Care Programme Approach No

Personal Information

FULL NAME: ☒ Mr / Mrs / Ms / Miss / Master LEON GRATTON		Where appropriate, likes to be known as: LEON	Previous or Maiden Name(s) /
Home Address 85 SPITALFIELD RD INVERVIEW TOWN Post Code		Date of Birth 17/3/75 Gender MALE	Place of Birth MANCHESTER
		Current Address SA Post Code	
Present/Past Occupation UNEMPLOYED		Religion and/or Chaplaincy requirement NONE	Marital Status Single Telephone No(s) /
Allergies NONE		Is English first language? Yes ☒ No ☐ Preferred Language	Ethnic Origin Scottish Sensory Impairment problem (s) NONE
		Is an Interpreter required? Yes ☐ No ☒ Name (relationship to client, if any)	
MHA Status Informal	Review Date	Patient Informed of Status By: Date:	Clinical Risk Yes ☐ No ☒ If yes; Specify Main Risk
Does the Adults with Incapacity Act Apply; Yes ☐ No ☒			Is there an Identified Relapse Signature? Yes ☐ No ☒
Refer to Care Plan No			If Yes; Refer to Care Plan No

Main Carer/Partner/Relatives/Named Person Information etc

(1) Full Name Does not want to give.	Home Address Post Code	Telephone No. Relationship
(2) Full Name	Home address Post Code	Telephone No Relationship
Does service user agree with the sharing of information with Carer / Nearest Relative /Partner Yes ☐ No ☒	Identify person to be contacted if patient is sick, dying or in any emergency.	Where appropriate - Order of Contact

Mental Health Directorate
ADMISSION INFORMATION SHEET [A1-1]

Patients Name LEON GRATTON Unit/CHI No F.S. 5.3883

Diagnosis

Relevant Medical Condition:

SCHIZOPHRENIA

Medication Concordance:

AS PER KARDEx

Community Service Involvement

	Name/Address	Tel No's
LMHT/Community Team		
General Practitioner DR GARMON	INVERKEITHING MEDICAL CENTRE	
Social Worker		
Community Psychiatric Nurse W F COT		01383- 432725
District Nurse		
Care Programme Approach Co-ordinator		
Home Care Manager		
Chaplain		
Dependants		
Other involvement	Richmond - msray	01383 622133

Client Financial Information etc

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

Nursing Observations

Temperature 36.3	Pulse 66	Blood Pressure 131/67
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Signature of Person Completing this Form: [Signature]

Date: 10/6/8

Mental Health Directorate
ADMISSION INFORMATION SHEET [A1-1]

NHS

Initial admission to Ward/Department: <i>Woodbank</i>	Community Service/Hospital: <i>W3H</i>	Date <i>8/6/08</i> Time <i>20:30</i>
Consultant: <i>Dr Smith</i>	Named Nurse/Case Manager <i>Jean Braide</i>	Unit No/CHI No <i>F5153833</i>
		Care Programme Approach No

Personal Information

FULL NAME: (Mr / Mrs / Ms / Miss / Master) <i>Leon Gratten</i>		Where appropriate, likes to be known as: <i>Leon</i>	Previous or Maiden Name(s)
Home Address <i>35 SPITAL FIELD RD INVERKETHING</i>		Date of Birth <i>17/3/75</i>	Place of Birth
		Gender <i>Male</i>	Marital Status <i>SINGLE</i>
Post Code		Current Address	Telephone No(s)
Present/Past Occupation <i>UNEMPLOYED</i>		Religion and/or Chaplaincy requirement	Ethnic Origin
Allergies		Sensory Impairment problem (s)	Is English first language? Yes ☒ No ☐ Preferred Language
		Is an Interpreter required? Yes ☐ No ☒ Name (relationship to client, if any)	
MHA Status <i>Informal</i>	Review Date	Patient Informed of Status By: Date:	Clinical Risk Yes ☐ No ☐ If yes; Specify Main Risk
		Does the Adults with Incapacity Act Apply; Yes ☐ No ☒	
		Is there an Identified Relapse Signature? Yes ☐ No ☐ If Yes; Refer to Care Plan No _____	
Refer to Care Plan No _____			

Main Carer/Partner/Relatives/Named Person Information etc

(1) Full Name	Home Address	Telephone No.
	Post Code	Relationship
(2) Full Name	Home address	Telephone No
	Post Code	Relationship
Does service user agree with the sharing of information with Carer / Nearest Relative / Partner Yes ☐ No ☐	Identify person to be contacted if patient is sick, dying or in any emergency.	Where appropriate - Order of Contact

Mental Health Directorate
ADMISSION INFORMATION SHEET [A1-1]

Patients Name Leon Gratten Unit/CHI No F5153833

Diagnosis

Relevant Medical Condition:

Hx Schizophrenia

Medication Concordance:

Poor compliance with prescribed medication.

Community Service Involvement

	Name/Address	Tel No's
LMHT/Community Team		
General Practitioner		
<u>DR GARMONY</u>	<u>INVERKEITHING MEDICAL CENTRE</u>	
Social Worker		
Community Psychiatric Nurse		
District Nurse		
Care Programme Approach Co-ordinator		
Home Care Manager		
Chaplain		
Dependants		
Other involvement	<u>Richmond - Moray</u>	<u>01383 622133</u>

Patient Financial Information etc

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

Nursing Observations

Temperature <u>35.1°</u>	Pulse <u>113/70</u>	Blood Pressure <u>66</u>
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Signature of Person Completing this Form:

A. YIOMD

Date: 8.6.08

Mental Health Directorate
ADMISSION INFORMATION SHEET [A1-1]



Initial admission to Ward/Department: WARD	Community Service/Hospital: QM H	Date <u>28/4/08</u> Time <u>2.03.0</u>
Consultant: DR CAVANAGH	Named Nurse/Case Manager	Unit No/CHI No
		Care Programme Approach No

Personal Information

FULL NAME: Mr / Mrs / Ms / Miss / Master LEON JAMES GRATO		Where appropriate, likes to be known as: m	Previous or Maiden Name(s)
Home Address 85 Spital Field RD Inverthwaite KY11 1DZ		Date of Birth 47/3/75	Place of Birth
		Current Address m	
Present/Past Occupation UNEMPLOYED		Religion and/or Chaplaincy requirement	Marital Status Telephone No(s) 01383 415625
Allergies NONE KNOWN		Is English first language? Yes ☐ No ☒ Preferred Language	Ethnic Origin Sensory impairment problem (s) NONE
MHA Status Informal	Review Date	Patient Informed of Status By: Date:	Clinical Risk Yes ☐ No ☒ If yes; Specify Main Risk Refer to Care Plan No _____
			Does the Adults with Incapacity Act Apply; Yes ☐ No ☐
			Is there an Identified Relapse Signature? Yes ☒ No ☐ ASB Skelton M.D.L. If Yes; Refer to Care Plan No _____

Main Carer/Partner/Relatives/Named Person Information etc

(1) Full Name GARY GRATTON	Home Address Jocchad Bree Manchester. Post Code	Telephone No. 0161 776 1420 Relationship
(2) Full Name LOANA GRATTON	Home address Post Code	Telephone No 07762602112 Relationship mother
Does service user agree with the sharing of information with Carer / Nearest Relative /Partner Yes ☐ No ☐	Identify person to be contacted if patient is sick, dying or in any emergency.	Where appropriate - Order of Contact

Mental Health Directorate
ADMISSION INFORMATION SHEET [A1-1]

Patients Name Leon Grafton Unit/CHI No

Diagnosis

Relevant Medical Condition:

Eczema
Asthma

Medication Concordance:

Clopidogrel RePot
Atrorlepan
Diolepan

Community Service Involvement

	Name/Address	Tel No's
LMHT/Community Team	Dawni Wfcot Leu	432 725
General Practitioner	DR GARMAN - Inverkerthin Sgus	413 234
Social Worker		
Community Psychiatric Nurse	Tom SHOOT - Wfcot	
District Nurse		
Care Programme Approach Co-ordinator		
Home Care Manager		
Chaplain		
Dependants		
Other involvement	Richmond Fellowship	01385622157

Patient Financial Information etc

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

Nursing Observations

Temperature	Pulse	Blood Pressure
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Signature of Person Completing this Form:

Date:

Fife Primary Care Division – Mental Health Directorate
ADMISSION INFORMATION SHEET [A1-1]

NHS

Initial admission to Ward/Department: Community	Community Service/Hospital: COT Team	Date Time
Consultant: DR CAVANAGH	Named Nurse/Case Manager TOM SHORT CRAIG MILL	Unit No/CHI No 1191
		Care Programme Approach No 194

Personal Information

NAME LEON GRATTON	Where appropriate, likes to be known as: LEON	Maiden Name N/A
	Date of Birth 17-3-75	Place of Birth Manchester
Home Address 85 SPITALFIELD RD. WIVERKEITHING.	Current Address Same	Telephone No 415625
Post Code	Post Code	mob 07516623988
Present/Past Occupation UNEMPLOYED	Religion and/or Chaplaincy requirement	Ethnic Origin white
		Sensory Impairment problem (s) none
Allergies none known	Is English first language? Yes ☒ No ☐ Preferred Language	Is an Interpreter required? Yes ☐ No ☒ Name (relationship to client, if any)
MHA Status Informal	Review Date	Tribunal Date
	Clinical Risk Yes ☒ No ☐ If yes; Specify Main Risk POTENTIAL FOR PHYSICAL AGGRESSION WHEN MENTALLY UNWELL OR UNDER THE INFLUENCE OF ALCOHOL / DRUGS.	Does the Adults with Incapacity Act Apply; Yes ☐ No ☒
		Is there an Identified Relapse Signature? Yes ☐ No ☒ If Yes; Refer to Care Plan No

Main Carer/Partner/Relatives Information etc

(1) Full Name LORNA GRATTON	Home Address none given	Telephone No. 07762602112
	Post Code	Relationship MOTHER
(2) Full Name GARY GRAFFON	Home address 57 Orchard Brace Manchester	Telephone No 01617761420
	Post Code	Relationship father
Does service user agree with the sharing of information with Carer / Nearest Relative / Partner Yes ☐ No ☒	Identify person to be contacted if patient is sick, dying or in any emergency. mother	Where appropriate - Order of Contact mother

ADMISSION INFORMATION SHEET [A1-1]

Patients Name LEON GRATTON Unit/CHI NoDiagnosis Schizophrenia - borderline personality Disorder

Relevant Medical Condition:	Medication Concordance:
Eczema Asthma	no difficulties can sometimes self medicate - change doses - Takes Build up - body building medication

Community Service Involvement

	Name/Address	Tel No's
LMHT/Community Team	WEST FIFE COMMUNITY OUTREACH TEAM	7432725
General Practitioner	DR GARMAN INVERKEITHING MEDICAL PRACTICE	01383 413234
Social Worker	N/A	
Community Psychiatric Nurse	Tom Short COT	01383 432725
District Nurse	N/A	
Care Programme Approach Co-ordinator	TOM SHORT	01383 432725
Home Care Manager	N/A	
Chaplain	N/A	
Named Person	none	
Other involvement	RICHMOND FELLOWSHIP (supporting people)	01383 622133

Patient Financial Information etc

	Where appropriate - Name/Address	Tel No's
Welfare Power of Attorney:	N/A	
Power of Attorney/Guardian/Curator:	N/A	
Pension Book etc held by:	N/A	
House Keys held by:	Self	
Insurance Number:		
Advanced Statement held at/with	none	

Nursing Observations

Temperature	Pulse	Blood Pressure
—	—	—

Signature of Person Completing this Form: Karen RichardsDate: 24/9/7

Fife Primary Care Division – Mental Health Directorate
ADMISSION INFORMATION SHEET [A1-1]

NHS

Initial admission to Ward/Department: <u>Community</u>	Community Service/Hospital: <u>COT Team</u>	Date Time
Consultant: <u>DR SAVANAGH</u>	Named Nurse/Case Manager <u>TOM SHORT</u>	Unit No/CHI No <u>1191</u>
	<u>CRAIG MILL</u>	Care Programme Approach No <u>194</u>

Personal Information		
NAME <u>LEON GRATTON</u>	Where appropriate, likes to be known as: <u>LEON</u>	Maiden Name <u>N/A</u>
	Date of Birth <u>17-3-75</u>	Place of Birth <u>Manchester</u>
Home Address <u>85 SPITALFIELD RD. INVERKEITHING.</u>	Current Address <u>Same</u>	Telephone No <u>415625</u> <u>mob 07516623988</u>
Post Code	Post Code	
Present/Past Occupation <u>UNEMPLOYED</u>	Religion and/or Chaplaincy requirement	Ethnic Origin <u>white</u> Sensory Impairment problem (s) <u>none</u>
Allergies <u>none known</u>	Is English first language? Yes ☒ No ☐ Preferred Language	Is an interpreter required? Yes ☐ No ☒ Name (relationship to client, if any)
MHA Status <u>Informal</u>	Review Date	Tribunal Date
	Clinical Risk Yes ☒ No ☐ If yes; Specify Main Risk <u>POTENTIAL FOR PHYSICAL AGGRESSION WHEN MENTALLY UNWELL OR UNDER THE INFLUENCE OF ALCOHOL / DRUGS.</u>	Does the Adults with Incapacity Act Apply: Yes ☐ No ☒ Is there an Identified Relapse Signature? Yes ☐ No ☒ If Yes; Refer to Care Plan No _____

Main Carer/Partner/Relatives Information etc		
(1) Full Name <u>LORNA GRATTON</u>	Home Address <u>none given</u>	Telephone No. <u>07762602112</u> Relationship <u>MOTHER</u>
(2) Full Name <u>GARY AARIE GIVEN GRATTON</u>	Home address <u>57 Orchard Brace Manchester</u>	Telephone No <u>01617761420</u> Relationship <u>father</u>
Post Code	Post Code	
Does service user agree with the sharing of information with Carer / Nearest Relative / Partner Yes ☐ No ☒	Identify person to be contacted if patient is sick, dying or in any emergency. <u>mother</u>	Where appropriate - Order of Contact <u>mother</u>

ADMISSION INFORMATION SHEET [A1-1]

Patients Name LEON GRATTON Unit/CHI NoDiagnosis Schizophrenia - borderline personality Disorder

Relevant Medical Condition:	Medication Concordance:
Eczema Asthma	no difficulties can sometimes self medicate - change doses - Takes Build up - body building medication

Community Service Involvement

	Name/Address	Tel No's
LMHT/Community Team	WEST FIFE COMMUNITY OUTREACH TEAM	7432725
General Practitioner	DR GARMANY INVERKEITHING MEDICAL PRACTICE	01383 413234
Social Worker	N/A	
Community Psychiatric Nurse	Tom Short COT	01383 432725
District Nurse	N/A	
Care Programme Approach Co-ordinator	TOM SHORT	01383 432725
Home Care Manager	N/A	
Chaplain	N/A	
Named Person	none	
Other involvement	RICHMOND FELLOWSHIP (supporting people)	01383 622133

Patient Financial Information etc

	Where appropriate - Name/Address	Tel No's
Welfare Power of Attorney:	N/A	
Power of Attorney/Guardian/Curator:	N/A	
Pension Book etc held by:	N/A	
House Keys held by:	Self	
Insurance Number:		
Advanced Statement held at/with	none	

Nursing Observations

Temperature	Pulse	Blood Pressure
—	—	—

Signature of Person Completing this Form:

Karen RichardsDate: 24/9/7

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



Patients Name Lean Carathan

Unit/CHI No

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)

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)

10 Nursing observation of patient physical state

Temperature 36.2 Pulse 72 Blood Pressure 126/82
Urinalysis _____ Skin State Intact Glasses _____ Hearing Aid _____
Dentures _____ Dentures Marked: Yes ☐ No ☐

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

General Appearance _____
Distinguishing features _____
Height _____ Weight _____ Build _____ Eye Colour _____
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)

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)

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)

15 Confusion problems experienced at home/previous care setting
(including level of memory impairment, level of disorientation in time place and person, confused behaviour)

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

Patients Name Leon Gration Unit No

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)

17 Other experienced at home/previous care setting

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

18 Emotional problems experienced at home/previous care setting

Complaining of inability sleeping at night.
Increased auditory hallucinations ongoing for 3-4 months.

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

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

Unit/CHI Number:

[illegible]

Patients/Client Name

Leon Gratton.

Unit Number / CHI

Date of Birth

17/03/75.

Named Nurse/Key Worker

Art; Shirley; Gdine.

Date: Time:	Multi Disciplinary Record of Important Information not held in Evaluation/Review/Variation Records etc	Signature
01/02/08 16 00	Informal admission following referral by WFCOT. WFCOT had attended house to administer depot Leon Complaining of derogatory & Command ^{recently} Suicide hallucinations reportedly took 8 Co-codamol ^{recently} last night, no recent assessors to current presentation; Seen on ward by Dr Ashwathi reported to not have slept last night due to "Voices; hallucinations you name it"; reported same ongoing for 3-4 months increasing volume and intensity. Reportedly took last overdose last night of 8 paracetamol, took all in one go 2 at a time every 2 hours with intention of "dying", reports no current suicidal ideation or plans stating would not end life because of his son; States mood is low 3/10 sleep 3-4 hours a night. At interview speech normal in rate; tone; rhythm with mood objectively euthymic. Bloods taken due to paracetamol overdose, Urtal obs taken on admission reading BP 126/82 P 72 Temp 36.2°C Flus, received depot on arrival to ward. Admit Informally General obs On call doctor to check bloods Can leave patient in hospital grounds at staff discretion	
20 12	Leon quickly settled on ward spending time between bedroom and courtyard; visited by his mother however not willing to speak with his mother, mother met with staff however Leon not wishing for information to be passed on; only wishing for mother to be told he was fine and will get things sorted out.	A. Masina
22.08 06 45	Leon spoke of reasons for admissions believes its still due to Gabe's death 1 year ago last night week. Woken for night sedation and slept well until 06.30 hrs.	Thaill
11 44	Leon early to rise does not appear to have attended to personal care complaining of a headache however not able to receive any analgesia due to awaiting blood levels taken on 1/2/08, Leon stating the headache appears to come and go advised to drink fluids and get some fresh air until results are received from the lab.	A. Masina
21 10.	No management problem complaining at times of Gabe, heads and noted to be laughing out loud at himself at one point saying that when he skits made him think of "Homer Simpson".	A. Hahn
21 20	Then Dr Olley Paracetamol results not	

Patients/Client Name

Leon GRATTAN

Unit/CHI Number:

Date: Time:	Record of Important Information not held in Evaluation/Review/Variation etc	Signature
2120	high enough to require treatment.	
3.2.08	Leon requested equine IBUPROFEN at 22.10hrs	
0705	Has slept little overnight. Only goes outside to smoke if staff present in day-room.	
1250	Leon has presented as reasonably settled. He has been heard to respond openly on several occasions to unknown stimuli, time spent between bed area and day room/canteen. No complaints offered.	
3/2/08	Leon has presented as settled in presentation 2000. No evidence of him responding to any unknown stimuli. Visited by his mother noted to have had a heated discussion with her she visited again later with some belongings for him which she had in her own house. She stated that he had asked him to go to her pub his house however she refused to do this as he accuses normally blames her for stealing his belongings.	
4/2/08	(NR) Leon has remained settled with no new problems. Slept well overnight.	
0640	Dr Cavanagh Pts mtg. - taken from notes.	
1403	Reports increased "voices" derogatory in nature, reports to not being as "depressed" and "lonely" in hospital. Mother visited yesterday arguing all the time; phoned mother after overdose last week; phoning Samaritans at times rather than mother as mother becomes annoyed - feels unsupported.	
	<u>Plan</u> Increase depot to Flupenthixol 100mg Diazepam reduced to 6mg. aim for discharge midweek.	
2012h	TENDING TO KEEP HIMSELF TO HIMSELF THIS AFTERNOON / EARLY EVENING. SPENDING MUCH OF HIS TIME SITTING AT HIS BED AREA, ALTHOUGH WITH OCCASIONAL VISITS TO SITTING AREA. LITTLE INTERACTION OFFERED ALTHOUGH QUIET ON APPROACH.	
(cont)	- CONTINUALLY SITTING IN HIS BED AREA APPEARS BORED IN MOOD. SHARING A JOKE WITH FELLOW PATIENTS IN THE DAY AREA.	
5/2/08	(NR) Leon retired to bed late into night still	
0655		

Patients/Client Name

Leon Gratton

Unit/CHI Number:

Date: Time:	Record of Important Information not held in Evaluation/Review/Variation etc	Signature
NB Continued	Continues to attempt Smoking in dayroom despite reminders from Staff regarding policy on same	<i>[Signature]</i>
5/2/08	Belated entry from 4/2/08 - p.m.	
09:20	Leon had short period off ward in the company of his Richmond Fellowship Support Worker, Neil yesterday evening. Hazel, Support Worker will escort Leon home on pass for 3 hours 5/2/08 to collect belongings he requires.	Abraham
02:25	Leon has been settled around the ward, although noted to be responding to unknown stimuli. Was visited for a short period of time this am by his mum.	<i>[Signature]</i>
52:8 (2030hrs)	Leon appearing bright and settled in presentation spending time socialising with Fellow patients in music room. Planned discharge on 6/2/08 discharge prescription completed. No concerns highlighted.	HT upon
6:2:08	Analgesia for Leonards. Remains settled	
07:15	slept well	<i>[Signature]</i>
15:10	Telephone call received from Leon's mother confirming discharge today confirmed planned for later this afternoon. Asked the person message that she will contact him tonight at his home. Some fuss. Leon quiet during the morning. Left the ward at 15:00 with discharge medication. Letter to be posted.	<i>[Signature]</i>
16:10	Leon was discharged today from the ward. Medication supplied, contacted his GP, NFEROT and Richmond house. Kardex for depot sent to Carnegie clinic	S. Bain

Patients/Client Name

Unit/CHI Number:

[illegible]

Observation Care Plan - GENERAL

Patient's Name Leon Gratton DOB 17/3/75 CHI/Unit No.
Ward 2 Responsible Consultant Dr. Carranagh

Physical Description

Height		Hair	
Weight		Build	<u>Tall / medium</u>
Eye Colour		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

Assessment of mood & mental state.

Specific interactions and limits to be applied

Prescribing Nurse Signature A. Matusz Grade Band 5 Date 01/2/08

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

Nursing Signature Date

Medical Signature Date

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

Review Notes Overleaf

REVIEW NOTES

Date	Observations / Decisions	Nurse's Signature

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



Patients Name LEON GRATTAN Unit/CHI No

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)

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)

Thoughts of overdose or self harm
and increased hearing voices.

10 Nursing observation of patient physical state

Temperature	Pulse	Blood Pressure
Urinalysis	Skin State	Glasses
Dentures	Hearing Aid	
Dentures Marked:		Yes ☐ No ☐

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

General Appearance _____
Distinguishing features _____
Height _____ Weight _____ Build _____ Eye Colour _____
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)

Physically - OK.

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)

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)

15 Confusion problems experienced at home/previous care setting
(including level of memory impairment, level of disorientation in time place and person, confused behaviour)

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

Patients Name Leon Gratton Unit No

- 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)

Denies Alcohol or Substances

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

Working with fitness - weights at home.

Isolated - little social contact.

- 18 Emotional problems experienced at home/previous care setting

Anxiety -

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

Admission following referral from GP

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

Previous Admission in Feb 08 - for 1 week.
For 0/0.

Occupational Health and Safety Advisory Service / January 2002

Client Handling Assessment Form

A. Client Details/Assessment

A. Client details	Date		
	Weight kg		
	Height mtrs		
	BMI		
Weight Bearing: yes/no Full/Partial/variable History of Falls: yes/no (please circle)	Equipment used by client: wheelchair stick hoist other zimmer collator		
Physical condition			
Client's comprehension / communication			
Handling constraints:			
Behaviour which may effect safe handling:			
Rehabilitation Programme:			
Action plan discussed with client/carer yes/no			

Date:

Signature:

Designation:

Patients/Client Name

Leon Graham

Unit Number / CHI

Date of Birth

Named Nurse/Key Worker

Date: Time:	Multi Disciplinary Record of Important Information not held in Evaluation/Review/Variation Records etc	Signature
25/4/08	Leon is a gentleman known to services with a psychiatric illness who has been contacting the west fife community outreach line on a couple of occasions today as it has in a home visit by s/n Dunn Stanley. He reported to them intent to take an overdose of diazepam and paracetamol, also slimming tablets, plans also to drink bleach and has access to these substances at home. This led to him being brought to ward for assessment by Dr Khan. He reports depressive symptoms over past few weeks and included hearing voices telling him derogatory comments about himself. He also says that his neighbours are making too much noise and he needs more rest from this and Leon was keen for admission also claims that he felt like killing himself and his neighbour. Reports poor appetite and poor sleep, however, he was taking 2 appetite suppressants - slimming pills. Currently lives alone but has had a recent argument with his mother which has been a factor in precipitating his admission. Due to intent to harm himself if not admitted and also has the means to carry out this plan from Dr Khan. • Admission to hospital due to risk of overdose / self harm • Assessment in ward 2 over weekend • Physical + bloods tomorrow • No Passes.	
26/4/08 06.30	Leon has been settled in presentation socialized well within the dayroom prior to retiring & has slept well overnight.	
26-4-08 12.15pm	Duration of the morning has been spent asleep in bed, remains there at time of reporting.	C. Reigh M. Callaghan
21-15	Settled in presentation, once only Diazepam 5mg, as per Kardex, Dr. Kumbhani to review Kardex with Leon this evening. Escorted pass to shop - no problems noted.	C. Reigh

Patients/Client Name	Unit/CHI Number:
Leon Garton	

Date: Time:	Record of Important Information not held in Evaluation/Review/Variation etc	Signature
27/4/08 0650 (NA)	Leon presenting as settled pleasant and appropriate given Nitrazepam 10mg at 2245 hrs retired to bed before midnight and appears to have slept well overnight	HAUTSWA
12-50	Leon up early, not attended to care needs - settled in manner, time spent between bed area and courtyard	CPayne
19-55	Presenting as settled around the ward spending time in dormitory mainly. Leon was asked and declined the ward based relaxation group.	PSchiano
28/4/08 07.00	Settled in presentation bright & sociable with fellow clients in dayroom. Given P.R.N NITRAZEPAM 10mg at 22.00hrs. late to settle appears to have slept from around 04.00hrs.	clad
28/4/08	Dr. Cavanagh ward round - taken from notes * Admitted to hearing voices / suicidal thoughts * Has been stressed due to social circumstances * Insomnia was * Had increased depot 2 weeks ago feels it helped * Voices have improved since admission. * 2 more days in the ward to review mental state * Passes increased to 4hrs if he needs to go home to get clothes.	MBSD
12.05pm	Aware early, unsure if attended to personal care needs. Contacted west fire community at Flack team to advised them of his admission to ward 2. Presenting as stable in mood and mental state throughout morning	Slavina
2.00	Appeared relaxed and settled until some time after seven he stormed off the ward. He came back a few minutes later ignoring me when I asked if he had been to the vending machine. Some time later, still looking flustered, I asked if anything was wrong. He said he was being raped, "fucked up the ass" all the time. I didn't ask him to elaborate. Sh. Schivone later told me that he had again asked for diazepam. When told it was n once only he left, only shrugging his shoulders. When I	

Patients/Client Name

Leon Gratton

Unit/CHI Number:

Date: Time:	Record of Important Information not held in Evaluation/Review/Variation etc	Signature
28/4/8 21:00	next saw him I asked if the two incit incidents were connected. He only said that "it would help." Sen Gibson told me later that Leon Gratton and Sen were talking when the latter asked "did you get anything?" Dr. Recusbrown, duty doctor, was told of all that had transpired same time after, after after Leon spoke with S/W Schiavone, Dr. Recusbrown prescribed him a once only diazepam 5mg.	A. Anderson
29/4/08 N/A 07:15	Has not slept overnight requested a dose given N. benzopreson 10mg at 22:15 hr but this has had no effect. Has spent the night going between day room and bed area. Mood appears bright laughing in the company of others.	Sumit
11:35	Leon has been settled around the time he went to the cafe with his support worker.	S. Row
4:30pm	Leon approached myself requesting discharge home. Contacted Dr. Kallabraman who arrived on ward to meet with Leon re - monitor for discharge home. Feedback from Dr. Kallabraman after consult: Leon to be discharged home bright. Follow up our patients with Dr. (Cavanagh) West Fife Community Outreach 3x weekly and Richmond Fellowship 5x weekly.	Sumit
6pm	GP, WFCST and Richmond Fellowship advised of Leon discharge. Discharge medication varied as per discharge sheet. Referrals and vision assessments start to be completed for WFCST. Telephone call received from pharmacy enquiring about frequency of diazepam medication. S/W Schiavone Schiavone clarified same with Dr. Kallabraman that Leon only to be given 1 x dose of diazepam 5mg, as same varied daily when in community. Pharmacy advised of the above.	Sumit

Unit/CHI Number:

[illegible]

Observation Care Plan - GENERAL

Patient's Name LEON GATHAN DOB 17/3/75 CHI/Unit No.

Ward 2 Responsible Consultant Dr Cavanagh

Physical Description

Height		Hair	
Weight		Build	
Eye Colour		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

Intent to self harm

Specific interactions and limits to be applied

Respite Admission

Prescribing Nurse Signature [Signature] Grade Date 25/6/08

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

Nursing Signature Date

Medical Signature Date

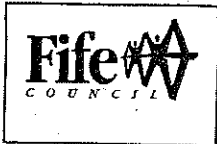
(Note: A medical signature is not essential when raising the observation level)

Review Notes Overleaf

Patients/Client Name

Unit/CHI Number:

[illegible]



Mental Health Risk Assessment Checklist



Patient/Client Name LEON GRATTON

Date of Birth 17/3/75

CHI/Unit No 1191

Past History

History of Violence (ever)

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

Tick

☐
☐
☐
☐
☒

Most serious harm caused

- None
Minor injury
Serious injury
Fatality

☐
☒
☐
☐

History of Suicide attempts (ever)

- None
One
Two
Three
More than three

☐
☒
☐
☐
☐

History of severe self neglect (ever)

- No ☐ Yes ☒

History of risk to children (ever)

- No ☒ Yes ☐

History of containment (ever)

- State Hospital
Secure Care
Section
PCU/Locked ward
Compulsory Admission
Temp Detention at Police Station

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

Incidents involving the Police (past year) (ever)

- None ☐
One ☐
More than one ☒

History of failure to take medicine

- No ☐ Yes ☒

History of unplanned cessation of contact

- No ☒ Yes ☐

Known Problems over the last year - ever

Tick all problems presented (in past year) (ever)

Accident harm at home (eg, falling, careless smoking) ☐ ☐

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

Alcohol abuse ☐ ☒

Arson (deliberate fire-setting only) ☐ ☐

Drug abuse ☐ ☒

Overdose ☐ ☐

Risk of abuse from others ☐ ☒

Risk to children ☐ ☐

Self-injury (eg, cutting) ☐ ☐

Other methods of self harm (specify).

Self-neglect ☐ ☐

Sexual Assault ☐ ☐

Violence to family ☐ ☒

Violence to staff ☐ ☐

Violence to other patients ☐ ☐

Violence to the general public ☐ ☐

Violence to specific other ☐ ☐

Other (specify) MOTHER

CAN BE AT RISK

FROM LEON, ALSO

LEON'S STEPFATHER

Patient/client name LEON GRATTAN CHI/Unit No

Detail of nature of risk:

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

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

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

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

Plan of Action

Date time of completion 1.8.06

Name in Block Capitals TOM SHORT

Designation C.C.M.

Signature T. Short

Ward /Dept 1W0

Name:

Leon Grattan

Care Plan Number

1

C.H.I. Number

1703751191

Unit Number

F 5153833

Date Commenced

10/06/08

Consultant/G.P.

Dr. Cavanagh

Prescribed By Named Nurse:

A. Anderson

Date Resolved

Description of Need:

Client is experiencing an altered mental state requiring admission to hospital for admission

Objective/Expected Outcome

To complete a nursing assessment of the client's mental state from admission, thus providing a basis for the formulation of the care particular to the client's need

Actual Outcome

Evaluation/Review No	Date Due	Evaluation/Review No	Date Due
1	<u>15/06/08</u> ✓	6	
2	<u>26/06/08</u>	7	
3		8	
4		9	
5		10	

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

Patient/Client Name Leen Gratton Unit/CHI No F5153833
1703751191

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.		10/06/05	A. Aulcay
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: -			

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:

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



Patients Name LEON CRATION

Unit/CHI No F.S.53883/1191

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)

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)

10 Nursing observation of patient physical state

Temperature 36.3 Pulse 66 Blood Pressure 131/67
Urinalysis N.A. Skin State Intact Glasses NO Hearing Aid
Dentures NO Dentures Marked: Yes ☐ No ☐

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

General Appearance Well kept
Distinguishing features TATOO LEFT SHANK
Height 6'2 Weight 13 stone Build MEDIUM Eye Colour BLUE
Hair colour BROWN Shoe Size Posture UPRIGHT

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 PROBLEMS AT PRESENT

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)

INDEPENDENT OF CARE

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 NOTED, LEON ALSO

15 Confusion problems experienced at home/previous care setting
(including level of memory impairment, level of disorientation in time place and person, confused behaviour)

CAN GET CONFUSED AT TIMES

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

Patients Name Leon Patton Unit No FS153833/1191

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)

CAN BECOME AGGRESSIVE AT HOME MORE SO AT NIGHT AND
SMASH HIS HOUSE UP.

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

18 Emotional problems experienced at home/previous care setting

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

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

PREVIOUS ADMISSIONS TO WARD TWO

Observation Care Plan - GENERAL

Patient's Name LEON GRATTAN DOB 17.3.75 CHI/Unit No F5153833
Ward WOODBANK Responsible Consultant Dr Smith

Physical Description

Height	<u>6' 2"</u>	Hair	<u>SHORT BLONDE</u>
Weight	<u>13st 3lb</u>	Build	<u>MEDIUM</u>
Eye Colour	<u>BLUE</u>	Dist. Features	<u>TATTOOS x 2 on chest</u> <u>TATTOOS ON UPPER ARMS</u> <u>AND UPPER BACK</u> <u>PIERCING IN (R) NIPPLE</u>

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

Unobtrusive general observations.
O.D.
Suicidal ideation
Low mood.

Specific interactions and limits to be applied

~~Nil time out at present.~~

Not deemed detainable at present.
To be seen by Duty Doctor if wishes to leave.

Prescribing Nurse Signature A. YLOND Grade S/N Date 2.6.08

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

Nursing Signature Date

Medical Signature Date

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

Review Notes Overleaf

REVIEW NOTES

Date	Observations / Decisions	Nurse's Signature
9/6/08	Escorted time out at nurse's discretion	

To be completed within 48 - 72 hrs of admission

Patients Name

Leon Gratton

Uni/Chi No

F5153833

(703751191)



[1] Memory/orientation needs:

Memory Short and long term appears intact. Reports no problems. Orientated to time, place and person.

[2] Behaviour needs: [Mental State]

Would appear to vary day to day. At times appears to be responding, and distressed due to seemingly delusional beliefs yet at other times does not seem to be effected.

[3] Communication needs: [Social interaction]

No problems. Good level of social interaction shown on the ward.

[4] Mood disturbance needs: [Mental State]

Variable since admission - by his account - currently bright, offering no complaints with regard to his affective state.

[5] Sleep needs:

Has been sleeping well bar one night where he didn't get any; to continue monitoring.

[6] Continence needs [Toileting]

No problems regarding this area of functioning.

[7] Washing/dressing needs [Self care]

Independent in attending to his self-care needs.

[8] Nutrition/weight needs, including Personal likes (sugar in tea/coffee etc)

No issues with regard to nutrition.

Patients Name Leon GrattonUnit/CHI No F5153833
1703751191

[9] Mobility needs

Nil problems ; mobilises independently.

[10] Skin/pressure care needs

Nil problems ; skin intact.

[11] Physical health/pain needs

No problems or concerns with regard to physical health.

[12] Medication

Receiving depot , flupenthixol , without protest.

Recently commenced on above but in tablet form with no reports of ill effects thus far.

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

Reports no difficulties with respect to this.

[14] Community Services

Receives community input from WFCOT and Richmond.

[15] Financial/clothing needs

Reports no difficulties with regard to financial / clothing needs.

Emotional / Psychological needs:

Is Patient / Client in receipt of pension book:

Yes ☐No ☒

Specify _____

Who holds Pension Book _____

Who holds house keys _____

Signature: A. Anderson S/W

CLIENT HANDLING ASSESSMENT FORM

A. Client Details/Assessment

A. Client details LEON GRATTAN 85 SPATTAN FARM ROAD INVERKEITHING F51S3833.	Date	8.6.08	
	Weight kg:	84kg	
	Height metres:	1.88m	
	BMI	24	

Weight Bearing: <u>yes</u> /no Full Partial/variable History of Falls: Yes/ <u>No</u> (please circle)	Equipment used by client: Wheelchair Stick Hoist Other... <u>NONE</u> Zimmer Rollator
--	---

Physical condition Good at present. Suffers from eczema.
--

Client's Comprehension/communication Can communicate freely. Is able to understand instruction. Orientated to time, place & person. No formal testing carried out.
--

Handling constraints: None at present.

Behaviour which may affect safe handling: NONE KNOWN at this time.

Action plan discussed with client/carer yes/no
--

--

Date: 8.6.08 Signature: A. MCDONALD Designation: S/N

[illegible]

[illegible]

Client's Name..... Hospital No:.....

DOB: _____

Signature:

[illegible]

C : Client Handling Action Plan**Client Name:****D.O.B:****HOSPITAL NO:****TASK No.... :****TASK No.... :**

Number of staff required

Number of staff required

Yes/No

Yes/No

Mechanical Hoist Required:

Yes/No

Mechanical Hoist Required:

Yes/No

Other moving and handling equipment:

Type:
Sling size/colour
sling type

Other moving and handling equipment:

Type:
Sling size/colour
sling type

Handling Instructions:

Handling Instructions:

Signature:

Date:

Signature:

Date:

TASK No.... :**TASK No.... :**

Number of staff required

Number of staff required

Yes/No

Yes/No

Mechanical Hoist Required:

Yes/No

Mechanical Hoist Required:

Yes/No

Other moving and handling equipment:

Type:
Sling size/colour
sling type

Other moving and handling equipment:

Type:
Sling size/colour
sling type

Handling Instructions:

Handling Instructions:

Signature:

Date:

Signature:

Date:

C: Client Handling Action Plan

Client Name:

D.O.B:

HOSPITAL NO:

TASK No.... :

TASK No.... :

Number of staff required Yes/No
Mechanical Hoist Required:

Type:
Sling size/colour
sling type

Number of staff required Yes/No
Mechanical Hoist Required:
Other moving and handling equipment:

Type:
Sling size/colour
sling type

Handling Instructions:

Handling Instructions:

Signature:

Date:

Date:

TASK No.... :

TASK No.... :

Number of staff required Yes/No
Mechanical Hoist Required:

Type:
Sling size/colour
sling type

Number of staff required Yes/No
Mechanical Hoist Required:
Other moving and handling equipment:

Type:
Sling size/colour
sling type

Handling Instructions:

Handling Instructions:

Signature:

Date:

Date:

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

Name: Leon Gratton Date of Birth: 17 / 03 / 75 CHI/Unit No: F5153833
 Address: 85 Spittal Field Road, Inverkeithing chi: 1703751191
 Post Code: KY11 1D2 Gender: Male

Date of Assessment: 23 / 06 / 08 Time: _____ Review Date: _____

Category of Risk

Assessment of Risk

From Others (e.g. abuse, exploitation)

Yes / No / Unknown

Details of identified Risk:

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

Yes / No / Unknown

Details of identified Risk: When mood is low or Leon is particularly stressed he can experience an increase in suicidal thoughts and has taken numerous impulsive O.D.s.

To Others (e.g. aggression, violence)

Yes / No / Unknown

Details of identified Risk: Potential for verbal or physical aggression when mentally unwell or under the influence of alcohol/drugs.

Neglect (e.g. health, personal appearance)

Yes / No / Unknown

Details of identified Risk: When mood lowers Leon can neglect his personal care, have a reduced appetite.

To Child(ren) (e.g. neglect, abuse)

Yes / No / Unknown

Details of identified Risk:

Physical Impairment (e.g. medical, sensory)

Yes / No / Unknown

Details of identified Risk:

Wandering & / or Falls

Yes / No / Unknown

Details of identified Risk:

Memory and Cognitive Impairment (e.g. forgetfulness)

Yes / No / Unknown

Details of identified Risk:

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

Yes / No / Unknown

Details of identified Risk: In the past Leon has failed to attend appointments, shown varied compliance with his prescribed medication regime

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

Yes / No / Unknown

Brief details: Leon has involvement with the COT team and Richmond Support

Patient Name: Leon Grattow

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

Leon has a longstanding diagnosis of schizophrenia. When unwell, especially when hearing persecutory voices, he has taken numerous impulsive overdoses. He has also experienced paranoia in the form of harbouring beliefs that people have been stealing things from his house, resulting in him making calls to the police. He has when unwell made threatening calls to the police, Ward Two and in the past has assaulted his mother.

Initial Assessment of Risk (including context, situations in which risk may occur and positive resources, potential for positive risk taking). Poor compliance with prescribed medication often figures in any deterioration in Leon's mood and mental state. This in turn is when Leon can be vulnerable to taking impulsive overdoses. He has also a longstanding difficulty in establishing any consistent sleep pattern. Consequently, when Leon has a degree of sleep deficit, he can experience an increase in voice hearing, paranoia or find it difficult to control his temper.

Initial Risk Management Plan (including who is responsible for what, identifying potential for risk taking): Dr. Cavanagh is, as responsible medical officer, in overall charge of co-ordinating Leon's care. In the community, Leon has contact with the outreach team and Richmond Fellowship who are able to assess his mood and mental state and also to help reduce his isolation and help him engage in both meaningful and rewarding activity. On the ward nursing staff have responsibility for monitoring mood and mental state.

Sources of Information Available for this Assessment:

- 1) Psychiatric Notes from outpatients appointments and past ward admissions.
- 2) Nursing staff with past experience of engaging with Leon.
- 3) Leon himself in person.

In What Way Has This Assessment Taken Place?

Through analysis of psychiatric notes and past risk assessments taken.

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

Comments:

Need For More Detailed Risk Assessment & Management:

YES

NO

Completed By:

Andrew Anderson

Date: 23/06/05

Discussed With:

Time:

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

Name: LEON CRISTIAN Date of Birth: 17 / 3 / 75 CHI/Unit No: FS153833
 Address: 85 SPITAL FIELD RD
INVERKEITHING Post Code: _____ Gender: MALE
 Date of Assessment: 28/6/08 Time: 2330hrs Review Date: / /

Category of Risk

Assessment of Risk

From Others (e.g. abuse, exploitation)

Yes / No / Unknown

Details of identified Risk:

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

☒ Yes / No / Unknown

Details of identified Risk: O.D. prior to admission. Hx of O.D's in past.

To Others (e.g. aggression, violence)

Yes / No / Unknown

Details of identified Risk:

Neglect (e.g. health, personal appearance)

Yes / No / Unknown

Details of identified Risk:

To Child(ren) (e.g. neglect, abuse)

Yes / No / Unknown

Details of identified Risk:

Physical Impairment (e.g. medical, sensory)

Yes / No / Unknown

Details of identified Risk:

Wandering & / or Falls

Yes / No / Unknown

Details of identified Risk:

Memory and Cognitive Impairment (e.g. forgetfulness)

Yes / No / Unknown

Details of identified Risk:

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

☒ Yes / No / Unknown

Details of identified Risk: Poor compliance with depot/prescribed medication.
Poor compliance with O/P appointments.

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

Yes / No / Unknown

Brief details:

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

Significant Known History (include known diagnoses & examples of risks taken):**Initial Assessment of Risk** (including context, situations in which risk may occur and positive resources, potential for positive risk taking):**Initial Risk Management Plan** (including who is responsible for what, identifying potential for risk taking):**Sources of Information Available for this Assessment:****In What Way Has This Assessment Taken Place?****Involvement and/or Agreement of Patient and/or Carer In Plan:**

Comments:

Need For More Detailed Risk Assessment & Management:

YES

NO

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

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

Patients/Client Name

LEON GRATTAN

Unit Number / CHI 1763751191
F5153833

Date of Birth

17-3-75

Named Nurse/Key Worker

JOAN BRAID

Date: Time:	Multi Disciplinary Record of Important Information not held in Evaluation/Review/Variation Records etc	Signature
8:6:08 2330hrs	Informal admission of 33yr old man. Transferred from Ward 8, QMH, for assessment. Medically fit after taking an overdose of Paracetamol @ 11³⁰hrs this morning. Has a history of schizophrenia. Well known to psychiatric services in Dunfermline. Complaining of feeling low and depressed. Describes feeling 'black'. Had bought Paracetamol 500mg x16, went home and took the tablets. After taking the tablets Leon then panicked and telephoned Samaritans. His father contacted emergency services who took him to Q.M.H. Has had numerous admissions to Ward 2 QMH. Was last discharged from Ward 2 on 6.2.08. Prescribed depot medication but missed last injection. Also missed last outpatient appt with Dr Cavanagh (Psychiatrist). - Lives alone in Inverkeithing. Is currently unemployed. In receipt of income support and D.L.A. Has 1 son with whom he is not in contact with (aged 9). Son lives with his mother. Leon was born in Manchester and brought up in Edinburgh. His Mother lives in Edinburgh but he hasn't been in contact for a few weeks. His Father lives in Manchester. He has 2 sisters whom he hasn't been in contact with for years. - Denies any alcohol use. Says he occasionally smokes cannabis but denies any other drug use. - <u>Plan</u> - informal admission to W.B.H. as no male beds in ward 2 Q.M.H. - depot due on Tuesdays - ? dose. - to be reviewed by Dr Smith. - not deemed detainable at present but to be seen if wishes to leave.	
9/6/08 6:31	Settled in to ward well. Watched TV. prior to referral - slept well overnight - still awaiting admission.	A. YLOND S/N
2:45	Leon has spent the morning between the sitting room and his bed space. He attended for lunch and has appeared settled around the ward.	JP
4:10	Richmond Fellowship phoned, will be attending the ward @ 11:30 to see Leon.	QJ S/N

Patients/Client Name

Leon Gratten

Unit/CHI Number: 703751191

85153833

Date: Time:	Record of Important Information not held in Evaluation/Review/Variation etc	Signature
9/6/08 4:00pm	Richmond taking Leon out to go home for some things	Abraham
10/6/08 6:10	c/o headache tonight given paracetamol 1g @ 21.40 with good effect. Stayed up & watch a film till around 01.00hrs slept for short period overnight.	Radford
10.50	Phone call received from staff nurse at Ward 2 in QMHT stating a staff member was on way to transfer Leon	jr
11.55	Leon was transferred from woodbank to ward 2 QMHT hospital, Since admission Leon has lay on top of his bed, he has since attended his lunch	SBarr
12.55	Leon requested to go home to get belongings in the company of his support worker, Margaret from Richmond Fellowship. Due to return 3pm.	Abraham
15.10	Margaret Hamilton, Richmond Fellowship accompanied Leon back to the ward. She feels he is brighter in mood. Has spoken of preferring being in the ward, to being at home. She feels the company of others benefits him. Spoke of him enjoying writing. Richmond Fellowship staff will visit ward 9.30 - 13.30hrs to see Leon, and see what he wishes to do.	Abraham
20.00	Received from Pam Richmond Fellowship asking how Leon was whilst in the ward, then asked to speak to someone in charge. She also was informed on how Leon was presenting. Settled, bright interacting with others/staff. Time spent with Ben and Andy watching DVD	E. Amos
8.10pm	Received from Leon's carer, who has been in the ward for 10 days, stating Leon is settled and has been in the ward for 10 days, stating Leon is settled and has been in the ward for 10 days, stating Leon is settled and has been in the ward for 10 days.	Abraham
11/6/08 07.10	NR) Leon late to retire requesting lorazepam to aid sleep same denied as had received night sedation spent time in dayroom before retiring around 03.00hrs.	Amasiwa
12.35	Dr Carranagh's meeting - Dr Recabarren will meet with Leon as she has not met with him since transfer to the ward	
12.40	Dr Recabarren is meeting with Leon at the time of writing will gain feed back after the meeting, Leon has been settled on the ward spending the majority in the dayroom he complained of a sore neck and arm he said he has experienced	

Patients/Client Name	Unit/CHI Number:
Leon Pearson	FS153833 170375191

Date: Time:	Record of Important Information not held in Evaluation/Review/Variation etc	Signature
	this for long periods he said it is like a trapped nerve the Doctor was made aware	S Bain
12.50	Feed back from Dr Recabarren Leon was expressing suicidal ideas Dr Recabarren would like Dr Cavanagh to meet with Leon before making a decision about discharge. Dr Recabarren also looked at Leon's arm. There is no concern possible trapped nerve	S Bain
8.05pm	Leon has presented as relaxed and in a good mood. Socialising with fellow clients, observed to be laughing with fellow clients on several occasions and singing whilst walking up ward corridor. He requested and to be reassured as required lorazepam medication at 10pm. Sam denied due to no evidence of anxiety symptoms. Also noted to be laughing with fellow client only a few minutes prior to monitoring as required lorazepam.	Slater
8.15pm	Seen by Dr Cavanagh, no feedback given. Staff still to gain feedback from Dr Cavanagh	Slater
2025.	At the shift change over, S/N Bain provided me with a schedule for which Leon's support workers will be visiting the ward for support time:	
	Friday 13/06/08 10 am to 2 pm with Sarah-Jane	
	Saturday 14/06/08 9 am to 12 pm with Gillian-Muir	
	Monday 16/06/08 2 pm to 5 pm with Gillian-Muir	
	These times have been discussed with Leon to still be made aware of the arrangements.	A Anderson
12/6/08	Leon presenting as bright and interactive with fellow clients no evidence of low mood, anxiety or agitation at times appearing to laugh uncontrollably in company of others; retired to bed and slept rising around 0500hrs loud and disruptive on waking requiring prompting not to bang doors as fellow clients were sleeping; in dayroom early morning quite sociable and bright with others.	A Anderson
10.10hrs	Feed back from Dr Cavanagh regarding review of Leon yesterday.	
	to remain inpatient for further few days to allow assessment of mood and mental state.	

Patients/Client Name

Unit/CHI Number: 170375191

T-5153833

Leon Gration

Date: Time:	Record of Important Information not held in Evaluation/Review/Variation etc	Signature
12/16/08	Leon has presented as bright in mood and sociable in room. He has shown no symptoms of anxiety and yet is requesting frequently to get Lorazepam as required. This has been refused as no symptoms requiring medication are evident. Delacaberen to review his as required medication.	Se...
2005	Presentation remains unchanged from this morning. He has been bright and sociable showing no (harm) symptoms of anxiety or low mood at all. He hasn't even requested any as required. benzodiazepines this shift.	A. Anderson
13-608 0710	For long periods in the evening Leon presented very animated and laughing loudly with fellow clients. Has tried to retire to bed as other clients left daytime, but was unable to settle. Alternated time between daytime and bed area. Noted to be laughing to himself quite uncontrollably at these times. Staff approached Leon to discuss his presentation. Stated he is quite disturbed at present, reported his belief that he has been targeted by the "Mafia" since he was a child and that his mother wants him dead. Has had to defend himself from this threat over the years. Feels he is experiencing flashbacks of these fears. When asked how things could be improved, Leon responded by stating he could have his novel published. No explanation of the relevance of this statement was given. Stated he is feeling stressed within the ward and that he could just "end it". Given lorazepam 1mg as per order to ease anxiety with effect.	CM Borge
12.25	Leon up early, met with Dr. Cavanagh - no feedback, no pa. Leon proceeded out on pass with support worker, returned appropriately - No problems noted.	Cavanagh
1530	Received phone call from Sarah McViness, at Richmond wishing to know if Leon is getting closer to any plans for discharge. Said we were awaiting FIB from Dr Cavanagh. Requested he phone her on 07810000647 when we know.	Se...
1545	Please call to Richmond Fellowship Advisor. Leon has passed as wishes advised. Then shown.	

Patients/Client Name	LEON GRANTON	Unit/CHI Number	703751191 F5153833
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Date: Time:	Record of Important Information not held in Evaluation/Review/Variation etc	Signature
15/5 10:15	Meets with LEON to arrange times for visit.	
1950	Active round the ward. He has been between his dormitory, courtyard and dayroom. He has been observed numerous times to be laughing to himself in the dormitory. He received his depot injections, Flupentixol 100mg. At the 1800hrs medication found it was noted that she had been prescribed 4mg of Flupentixol Decanoate! There was some uncertainty about whether it was supposed to be Flupentixol or Zuclopentixol tablet as in Dr. Ricciabroni's notes it mentions below commencing on Zuclopentixol / Ciopixol. Dr. Gundi, duty doctor, was contacted and came to the ward. He has prescribed 3mg Flupentixol. His once only of this which was also written up has not yet been given due to there not being any in stock (and it was just prescribed at 2000 with no time yet to find out from other wards if they have stock).	
16/5 16:00	Settled evening, no evidence of responding to prompt. n/a disturbance this evening. Leon appears to have slept well overnight.	
14/6/08 12:15	Leon has been out with his Richmond Fellowship support worker this morning. Settled morning.	
2000	Leon approached staff early afternoon stating he needed Lorazepam, when asked to describe his symptoms, he described psychotic symptoms and was advised that staff would consult medical staff. Leon has been prescribed Chlorpromazine for same. Leon also requested and was given PRN Paracetamol for pain on his ribcage. Leon has since been observed bright in mood and is conversing well with fellow clients and staff.	
	Received chlorpromazine 50mg prn as per Kardex.	
14/5.6.08 14/6/08	Leon has not slept at all overnight despite receiving prescribed clonazepam 10mg at 10pm. Bright and sociable in mood; often observed to be giggling to himself.	
15.6.08 12:55	Leon was early to rise appears settled in presentation, bright and reactive, spending time with peers. Requested PRN ELS cream for leg irritation.	

Patients/Client Name

Leon Grattow

Unit/CHI Number:

F5153833 / 1703751191

Date: Time:	Record of Important Information not held in Evaluation/Review/Variation etc	Signature
15/6/8 2015	Leon has been active around the ward, spending time between the dormitory and courtyard. He hasn't really settled in any one place for any significant length of time. He hasn't approached staff looking for any benzodiazepines and hasn't been observed to be displaying any symptoms indicating any anxiety. He has been bright and sociable. In addition there haven't been any reported instances of Leon laughing/giggling to himself. I spoke with him in order to complete his 72 hr assessment. This didn't raise any concerns on his part: mood is fine, no suicidal ideas and no overt signs/symptoms of psychosis. Throughout he was talking freely, making sense and very appropriate.	A. Aulice
15/6/8 16.00	In bed from start of shift, and has slept for lengthy periods overnight.	JAH
13.30	Leon has been seated around the ward, overfamiliar with staff at times i.e. comments - No problems.	Playter
14.00	In Coronagh's word round. Leon denies hearing or responding to voices, saying he is only laughing at things he has seen on television. Dr Coronagh feels Leon needs a few more days on the ward, to be reviewed for discharge later in the week.	JA
20.05	On the whole settled on the ward. At time he has requested medication for anxiety without there being any evidence of his suffering any. He has accepted refusals with explanation without any protest. No evidence of any psychosis either.	A. Aulice
16/7.6 NIR 06.15.10	Leon spent a restless night on the ward, appeared to interact well with other clients. Has slept for long periods.	A. Aulice
12.10	Early to rise initially. Then returned back to bed where he remained at time of report —	ENR
16.50	Telephone call received from Fiona Hunter to enquire if Leon had pass status to meet with herself and Richmond Fellowship staff at his home tomorrow at 1.30 for Richmond assessment - Informed Leon of same - P. Seivada	

Patients/Client Name

Leon Gratton

Unit/CHI Number: F 5153833

CHI/1703751191

Date: Time:	Record of Important Information not held in Evaluation/Review/Variation etc	Signature
17/6/08 20.45hrs	Leon has been settled throughout shift. Approached staff asking for something for his "hemor". Spoke with Leon and advised that staff had not observed a "hemor" throughout shift. Leon then said that he was hearing his sons voice and went on to discuss his concerns about his sons safety. Chlorpromazine 50mgs given offered and accepted at 19.05hrs with good effect.	
18/6/08 04.00hrs	Continues to appear generally settled on the ward. Slept for long periods away from ward. Leon was up bright and early this morning. Left ward with support worker to meet with Fiona Hunter and Richmond Fellowship staff at his home. Appeared settled and bright in mood before leaving.	J. Hoban
12.50	Dr Savanagh's meeting • Awaiting feedback from Richmond • Overnight pass Thursday 19/6/08 • Weekend pass • Plan for discharge Monday 23/6/08	
18/6/08 17.05	Spoke to Leon regarding overnight pass and what he planned at the weekend. He appeared surprised, shocked and quite upset at the thought, saying "I will never manage an overnight pass", spoke about his neighbour and how if he 'started' he would try to hang himself. Approached me later regarding same to say he would "top himself" if he went home overnight. Leon appears quite calm, no anxiety, mood appears euthymic even when he is telling me this. I also approached him earlier in the day for a UDS which he agreed to provide and informed me when he needed to go, however stated he could not go with staff outside the toilet.	P. Schiasson
	UDS - ve to all urinalysis - NAD.	MM Intosh
19/6/08	Leon has been quite settled and chatty this afternoon but appears bored and fed up.	MM Intosh

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

Date: Time:	Record of Important Information not held in Evaluation/Review/Variation etc	Signature
19/6/08 06:30 n/a	Watched Football on T.V. in the company of fellow patients. then played some cards. enjoyed a carry out meal. Requested PRN medication for agitation at 08-10 hrs and was given PRN Chlorpromazine 50mg at 0820 hrs slept soundly overnight.	ad.
19/6/08 12:05hrs	Leon has been up early this morning. Appears bright in mood. Socialising appropriately with other patients and staff. No concerns at time of writing.	J. Hoban
20/06/08	At first Leon wasn't very keen to proceed on his overnight pass which had been planned at Dr. Coughlin's team meeting on 18/06/08. Some time later he changed his mind, proceeding out on pass due to return Friday 20/06/08 in order to collect further pass medication for the weekend.	A. Anderson
20/06/08	Leon returned to the ward in the early afternoon in order to collect further pass medication; he received his depot. This is next due on 27/06/08. He proceeded back on pass and as due to return on Sunday morning 22/06/08.	A. Anderson
21-6-08 06:25	Leon made several phone calls to the ward. 1st 2 were for his Dad to receive a psychiatric report. Then he phoned x2 saying he was bored. At 2pm he phoned to say he had taken 2 days supply of Fludopenthine 2 x 3mg tabs for today + 10 for tomorrow. Although Leon said he'd taken 18mg tabs. He was advised of his rashness of taking tabs and also taking responsibility for his actions. Said at first he'd taken them to stop voices from upstairs, then because he felt like shit, he said if he'd wanted to take a proper overdose he could have taken Paracetamol - as well. Again reminded of taking responsibility for actions. Advised to contact NHS 24.	R. Hall
1935	1. Contacted Holdane House to inform them of Leon's phone calls to the ward with the night shift. I spoke with a female there who at no point throughout the conversation said that they would or even try to, make contact with Leon to see how he was coping at home. No contact with either since this.	A. Anderson

Patients/Client Name:

Leon Gratton

Unit / CHI No. F 5153833

Named Nurse/Key worker

S/W Pagne, S/W Anderson, N/A Callaghan

Care Plan No

1

Date:

Time:

Record of Evaluation and / or Review

Signature

21/6/8

① Observation Level

From time of admission Leon has been nursed at General Observations level. This has remained in place to this evaluation. This has been deemed the most appropriate level of intervention to allow staff to assess his mood and mental state, to ensure his and others safety and preserved and to give Leon space

② Behaviour, Social Interactions, Activity Participation

At the start of admission Leon was consistently seeking out staff, complaining of distressing anxiety and therefore required to help him cope. Often overt symptoms were absent or behaviour prior to the request being made did not tally with his reports re. his internal state. This has been consistently been fed back to Leon. He has been advised to employ other measures to aid his coping and to use medication as a last resort. There has been a marked reduction in this behaviour. Leon has often been observed to be behaving in a manner suggestive of psychosis. He isn't always distressed, has spoken with staff when finding it difficult but when the former, is less forthcoming in describing his experience.

He hasn't isolated himself on the ward, or shown any difficulty in socialising.

Leon has been engaging with his Richmond support workers in accordance with the documented schedule.

③ One to One Key Worker sessions.

There haven't been any problems with Leon engaging with keyworkers. These are ongoing on both a formal and informal basis.

④ Multi-disciplinary Team Meeting

This has been ongoing since admission, including contact with the community outreach team when Leon is out on pass and with Richmond support workers when attending the ward.

Leon Gratton

F5153833

*Mental Health Nursing Service
Evaluation Sheet Feb 03 - Review Feb 05*

Patients/Client Name	Unit/CHI Number:
Leon Grattin	F 515 3833 / 1703751191

Date: Time:	Record of Important Information not held in Evaluation/Review/Variation etc	Signature
20/6/08	Leon has requested and given his consent to be treated by at 1320 and 1805 for pain as symptomatic relief. He has been off the ward for short periods at sleep machine and has been watching football.	S. E.
23/6/08	Enjoyed company of others, watched football. Retired. Has slept well overnight.	P. Schiavone
07/10	Dr Cunningham's meeting - He spoke about Leon's progress and taking tablets. Leon said he was hearing voices in and outside his head he only took the tablets to make the voices stop. at present he has no suicidal thoughts. The plan for Leon this week is for him to stay on the ward today, then go on pass Tuesday 24/6/08 until Friday 27/6/08 and attend the depot clinic at Carnegie on Thursday. A Kardex has been done and will sent to Carnegie. Richmond has been contacted regarding his progress and they will contact Haydon House as they support him on Thursdays for his depot at Carnegie clinic. His depot injection has also been increased. Flupentixol decrease 100mg - to 150mg. Pass medication has also been ordered.	S. B.
12:30	Leon has been settled on the ward. spent time between courtyard and dorm. bright in manner. no problems noted. Had short pass home with support worker Richmond Fellowship this morning, to visit his home.	R. Abraham
1:30	Leon attended the relaxation group - objectively Leon appeared to engage well taking on board the relaxation techniques with good settling effect. Leon has been settled in presentation, bright in mood spent some time off the ward with staff and fellow clients, humour evident, no concerns to note.	P. Schiavone
24/6/08	NR) Leon appearing settled and sociable with fellow clients, late to retire to bed getting up numerous times overnight appears to have slept little overnight.	A. M. S. W. A.
07/05	Leon was seen by Dr Cunningham this morning - plan is he is to go on pass until Friday but return on a daily basis to collect his medication as he is on duty dispensing from	

Patients/Client Name

Leon Gratton

Unit/CHI Number:

F5153833/1191

Date:
Time:

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

Signature

his local pharmacy Leon has now left the ward on pass he is aware as is his support worker that he is to attend Carnegie clinic on Thursday for his depot injection.

25/6/08 From Dr Carranagh's meeting: Leon to receive his depot at Carnegie clinic ~~tomorrow~~ On pass till Friday

13:30 to be reviewed on Friday No change to treatment plan.

26/6/08 Leon contacted the ward at 0830 this am to say he would collect his night injection at around 11am but he

1235 not yet attended the ward. Also contacted depot clinic

to advise he had dept in and moved his depot

although he had phoned him at 0830 also to say he would

attend. Arrive Leon contacted ward to ask if

he could receive his depot on ward 2 today as he

hasn't been able to attend depot clinic.

1605 Leon contacted the ward around 1515

asking about results about a kidney

test, I advised him he would need to

special with Medical staff regarding this

I then asked Leon when he was returning

to the ward and that he was when his depot

Leon was vague about his depot

but I assured him it was today.

I asked Leon when he was returning

to the ward and he said he had an

appointment with the nurse at his GP

practice at 1740 today and he

regarding "Problems down below"

and he would return to the ward

after this. I spoke Dr Beccaloni away

of this and he spoken with Dr Carranagh.

Leon does not return this evening

he is to be placed on overnight pass -

26/6/08 Leon returned to the ward as

1900 planned depot not due until Friday

according to Kardex (was only to be

given today due to depot clinic)

He was given his Nifedipine as

pass medication due and has left

the ward on a further pass due to

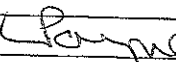
return tomorrow.

Patients/Client Name _____

Leon Gratton

Unit/CHI Number:

F5153833 / 1191

Date: Time:	Record of Important Information not held in Evaluation/Review/Variation etc	Signature
1455	Sean still to return to the ward at time of writing. In Dr Keshavan Mr. change to plan of care passes to continue as agreed	
17.20	Sean received dept medication today as per Kardex next due to be given 3/7/08 @ dept clinic. Carnegie clinic - WFOT informed of same & of discharge today. A.P. & Richmond Fellowship also informed of discharge. Discharge script sent to A.P. no medication given as Sean informed staff he had dated this over with his GP. Whilst on pass this week. Follow-up - WFOT & Richmond Fellowship	 

Patients/Client Name

Unit/CHI Number:

[illegible]

Fife Primary Care NHS Trust

Whyteman's Brae Hospital
Kirkcaldy, KY1 2ND



NURSING TRANSFER LETTER

Name: Leon Gratton
Address: 85 Spittalfield Road,
Inverkeithing

Tel No:

Next of Kin:
Address:

Consultant: Dr Smith
Religion: ?

D.O.B.: 17/13/75
Unit No: F5153833
G.P.: Dr Harmony
Address: Inverkeithing Medical Practice

Vo.:
Relationship:

Social Worker:
Mental Health Officer:
C.P.N.:

Informed of Transfer ☒ Yes / No
Diagnosis: Schizophrenia
Transfer From: Woodbank

Status: Informal
To: Ward 2 QMH

Review Date:

MENTAL STATE

Neurosis:- Anxious
Agitated
Obsessional
Phobias
Elated
Depressed — Low mood.

Psychosis:- Hallucinations
Delusions

Other:-

anic: Short Term Memory Impaired
Long Term Memory Impaired
Disorientated - Time/Place/Person

PHYSICAL STATE

Mobility:- Ambulant
Ambulant with walking aid
Ambulant with nurse/nurses help
Weakness - Left/right
Partially blind
Registered blind
Non-Ambulant

Sleep:- Sleeps well
Regular sedation
As required sedation
Difficulty getting to sleep
Early morning waking
Sleep walking
Prone to nightmares

Other:- Specify

Continence:- Fully continent
Incontinent of faeces/urine
Requires prompting
Requires regular toileting
Laxatives / Apperients
Continence Aid - specify
Searby score

Feeding:- Independant
Requires assistance
Binges/Vomits
Appetite - Poor/Good
Requires special aids
Special diet - specify

Communication:- Independent
Mute/Deaf
Talkative/Withdrawn
Shouts/Quiet spoken
Uses sign language/Brail
Hearing aid/Spectacles
Language difficulty - specify

Self Care:- Independent
Requires prompting
Assist to dress/undress
Assist to bath
Uses aids - specify

<u>Medical Condition</u>	<u>Skin Condition</u> Good. Waterlow Score: 3
--------------------------	---

OBSERVATION STATUS

Special

Nurse Escort

Passes Escorted time out

RISK FACTORS

SPECIAL TREATMENTS

Suicide

Self Harm

Absconding

Wandering

Aggression - Verbal/Physical

Fire Raising

Other

SOCIAL CIRCUMSTANCES

FINANCIAL

Unemployed.
Lives alone.
Has a year old son

Med 10 due 15/6
Income support
DLA

<u>Medication</u> As per Kardex <u>Depot</u>	<u>Allergies/Adverse Reactions</u> None Known.
--	---

Comments

Transferred from Wd 8, QMH after O.D. paracetamol 16x 500mg.
Phoned Samaritans, then father contacted emergency services.
Has history of poor compliance with depot/prescribed medication

Signature

R 2

Date

10/6/08

Patients/Client Name		Unit/CHI Number:
Leon Grattin.		

Unit/CHI Number:

[illegible][illegible][illegible][illegible][illegible]

Unit/CHI Number;

[illegible][illegible]

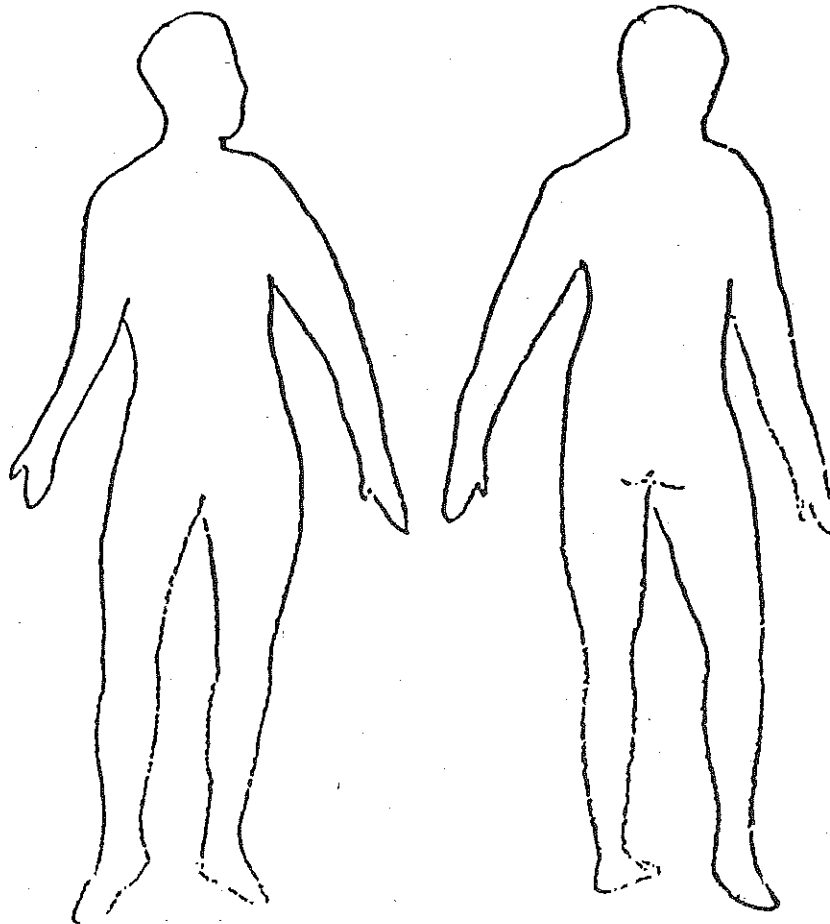
WATERLOW ADMISSION SCORE: 3

[illegible]

Front

Back

LEON GRATTAN

WATERLOW SCORE

10+ At Risk

15+ High Risk

20+ Very High Risk

Build/Weight for Height	Skin Type Visual Risk Area		Sex / Age		Special Risks
Average <u>0</u>	Healthy <u>0</u>		Male <u>1</u>		Tissue Malnutrition
Above Average 1	Dry 1		Female 2		Terminal Cachexia 8
Obese 2	Tissue Paper 1		14-49 <u>1</u>		Cardiac Failure 5
Below Average 3	Oedematous 1		50-64 2		Peripheral Vascular Disease 5
Continence	Clammy (Temp) 1		65-74 3		Anaemia 2
	Discoloured 2		75-80 4		Smoking <u>1</u>
	Broken 3		81+ 5		Neurological
Continent <u>0</u>	Mobility		Appetite		C.V.A.
Catheterised <u>0</u>	Fully <u>0</u>		Average <u>0</u>		Motor/Sensory 4-6
Occasional	Restless 1		Poor 1		Paraplegia
Incontinence 1	Apathetic 2		Fluids only 2		Diabetes
Catheterised	Restricted 3		NG Tube 2		Multiple Sclerosis
but incontinent	Inter 4		Nil by Mouth / 3		Major Surgery Trauma
of faeces 2	Traction 4		Anorexic 3		Orthopaedic / Below
Doubly	Chairbound 5				Waist Spinal 5
incontinent 3					On Table > 2 Hours 5
					Medication
					Anti-inflammatory
					Cytotoxics 4
					High Dose Steroids

Ward /Dept WHYTEMAN'S BERE - WOODBANK WARD

Name: <u>LEON GRATTAN</u>		Care Plan Number 1	
C.H.I. Number	Unit Number <u>F5153833</u>	Date Commenced <u>8.6.08</u>	
Consultant/G.P. <u>DR SMITH</u>	Prescribed By Named Nurse: <u>JOAN BRID</u>	Date Resolved	
Description of Need: Client is experiencing an altered mental state requiring admission to hospital for admission			
Objective/Expected Outcome To complete a nursing assessment of the client's mental state from admission, thus providing a basis for the formulation of the care particular to the client's need			
Actual Outcome			

Evaluation/Review No	Date Due	Evaluation/Review No	Date Due
1		6	
2		7	
3		8	
4		9	
5		10	

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

Patient/Client Name _____ Unit/CHI No _____

ACTION TO BE TAKEN: -

CARE PLAN – Admission to Acute Ward

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: -*

Monitor M.D.L's

Date

Signature

2.6.08

A. Yland

2.6.08

K. Yland

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 Division - Mental Health Directorate
Episodes of Care Sheet A1-EC

Patients Name LEON GRATTAN Unit/CHI No
Episodes of Care: Page

Area	Referred by	Reason for Referral	Admission / Contact Date	Named Nurse	Discharge/ Transfer date	Outcome/ Discharges to
WOODBANK WARD WHYTEMAN'S BEAR	Q.M.H.	O.D. this am. Low mood Suicidal Ideation.	2.6.08	JOAN BEALD		

Primary Care Division - Mental Health Directorate
Episodes of Care Sheet A1-EC

Patients Name

Unit/CHI No

Episodes of Care: Page						
Area	Referred by	Reason for Referral	Admission / Contact Date	Named Nurse	Discharge/ Transfer date	Outcome/ Discharges to

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



Patients Name Leslie Gratten

1703751191

Unit/CHI No FS153833

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)

Came on ward himself, noted aware in wards

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, to try to get out of cycle of taking drugs (speed).

10 Nursing observation of patient physical state

Temperature 35.8

Pulse 87

Blood Pressure 132/65

Urinalysis NAD

Skin State Eczema/dermatitis

Glasses no

Hearing Aid no

Dentures Yes

Dentures Marked:

Yes ☐

No ☒

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

General Appearance Unshaven, casually dressed.

Distinguishing features

Height 1.86

Weight 72kg

Build medium

Eye Colour Blue

Hair colour Short brown

Shoe Size 11

Posture Upright

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)

Weight loss over 6 weeks, Approx 2-3 stones

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 over past 6 weeks.

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 Groatton Unit No 17037511A1
F5153833

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

Low in mood.

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

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

2009 QM H.