NHS Fife, Queen Margaret Hospital, Whitefield Road, Dunfermline KY12 0SU
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NHS Fife

Date: 03 July 2026
Your ref: 100048
Enquiries to: Legal Services
Direct line: 01383 674101

Our ref: JW/SK/SR26/1400

Email: Fife.LegalServices@nhs.scot

MMA Legal
43-59 Princes Street
Stockport
SK1 1RY

1 of 2

* Voluminous records sent in 2 packages *

(Volumes 1-4 MH Sci-Store medical casenotes attached hereto)

Dear Sir

Your Client: Leon James Gratton
Address: 3 Makgill Row, Cupar, Fife, KY15 5SA
Date of Birth: 17/03/1975

I refer to your letter of 29 April 2026 and as requested, I now enclose copy medical records of NHS Fife relating to your above-named client and trust that these will be of some assistance to you. Volumes 1-8 of your client's notes are enclosed. Volume 9 has not been made available to us. It is with your client's consultant as he is a current patient.

Please note that these copy records are being provided to you for your purpose only and have **not** been reviewed by the treating clinician to ascertain if they contain any information which may cause either physical or mental harm to the patient or other persons. If it is the case that your client wishes copies of their health records, they should be asked to contact Access to Health Records Department, Victoria Hospital, Kirkcaldy, Fife, KY2 5AH who will process their request.

Yours faithfully

J Whitfield

Joanna Whitfield
Legal Services Manager

MENTAL HEALTH CASENOTES: VOLUME 4

Fife NHS Fife

Mental Health Services

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

Name: LEON GRATTON Date of Birth: 17 / 03 / 75 CHI/PIN No: 1703751191

Address: C/O DUNINO WARD
STRATHEDEN

Post Code: Gender M

Period/Date of Assessment: From 06 / 09 / 12 to / /

Complete any details of identified Risk below:	Assessment (Circle relevant answer)
From Others (e.g. abuse, exploitation) LEON VULNERABLE TO EXPLOITATION. APPEARS TO BE EASILY LED BY OTHERS. PREVIOUS ASSOCIATION WITH DRUG DEALERS SPENDING TIME IN HIS HOME	No / Unknown / Yes
To Self (e.g. suicide, self harm) IMPULSIVE BEHAVIOUR. SIGNIFICANT HISTORY OVERDOSE ATTEMPTS USE OF ILLICIT SUBSTANCES)	No / Unknown / Yes
To Others (e.g. aggression, violence) SIGNIFICANT HISTORY VIOLENCE TOWARDS MOTHER & STEP-FATHER - THIS IS NOT CURRENT BEHAVIOUR NOTED TO BE UNCOMFORTABLE TOWARDS FEMALES ON HOME VISITS)	No / Unknown / Yes
Neglect (e.g. health, personal appearance) MOTIVATIONAL ISSUES	No / Unknown / Yes
To Child(ren) (e.g. neglect, abuse)	No / Unknown / Yes
Physical Impairment (e.g. medical, sensory)	No / Unknown / Yes
Wandering & / or Falls	No / Unknown / Yes
Memory and Cognitive Impairment (e.g. forgetfulness)	No / Unknown / Yes
Challenges to Services (e.g. inappropriate demands, poor compliance MADE FALSE ALLEGATIONS - JOINT VISIT WHEN IN COMMUNITY SPORADIC ATTENDANCE AT DEPOT CLINIC	No / Unknown / Yes
Strengths/Positive Attributes (e.g. positive resources, agreed plans) ADMISSION FOR 6-WEEK ASSESSMENT	No / Unknown / Yes

Name Leon GRATTON Mental Health Services CHI/PIN No. 170325 1191

Summary of Assessment *(General Overview of situation)*

Admitted Dunino for 6-week assessment, mental health issue, some fixed beliefs but not distressed by these. Feels unable to return home as he is vulnerable to exploitation from others. Leon wants to engage with OTs and 6-week assessment process. Current behaviour appropriate, not violent or intrusive

11/1 – noted expressing paranoid delusions concerning mother

noted on previous RA1 – that 27/6/10 reported by Barbara Barnes (child family social worker) that Leon allegedly admitted to feeling sexually aroused around young children when he was younger – discussed by police, no further action taken

Client involved Yes ☐ No ☑

Carer Involved Yes ☐ No ☑

Discussed with other agencies: please specify.....

.....

Comments:.....

.....

**If required, please continue on a continuation/evaluation sheet*

Completed By: Lyn Nelson Date: 30/1/12 Time 15:30

Need For More Detailed Risk Assessment & Management:

NO ☐ **YES** ☐ *If yes please go to RA part 2*

Areas as per 6-week assmt

PSYCHIATRIC CASE SUMMARY
Date: 19 March 2012

CASENOTE NO.: SF5153833A

SURNAME: Gratton

FORENAME: Leon

D.O.B.: 17.03.75 **CHI:** 1703751191

DATE OF CURRENT ADMISSION: 06.01.12

WARD: Dunino

Mr Leon Gratton is a thirty six year old man who is currently a patient in Dunino rehabilitation ward on an informal basis. He has a longstanding history of schizophrenia, drug misuse and depression. His current admission began in September 2011 when he was admitted to Ward 2 at Queen Margaret Hospital with worsening in mental state, increased substance misuse and generally becoming more chaotic. He was found to be living in squalor by the Community Outreach Team and his self-care was extremely poor. He was preoccupied with delusions and there was evidence of increased perceptual disturbance. Leon was referred to the Rehabilitation Service and was transferred to Dunino on 10 January 2012. He recently had a six-week assessment on 11 February 2012.

Personal History

Leon was born in Manchester and moved to Scotland when he was two. His parents separated when he was three years old. His childhood was uneventful up to the age of thirteen, when his mother divulged that she and her sister had been sexually abused during childhood by their father. This disclosure caused a family row, with the mother and son being ostracized from the rest of the family. She shared full details of her allegation with Leon, who subsequently became very disturbed and preoccupied with the whole issue. He spent from the age of fifteen to sixteen in children's homes and left school at fifteen with no qualifications. At that time he was abusing drugs including LSD, amphetamines and cannabis. He described from age sixteen to eighteen doing "everything I could to annoy my mother". In 1993 he took acid and following this became increasingly disturbed and paranoid, leading to his first admission at the Royal Edinburgh Hospital. He has a patchy employment record. He has had several jobs after leaving school, the longest being for four months. He moved around the country a bit, taking seasonal work. In 1996 he moved to Lanarkshire. He married his now ex-wife, Liz, a social worker who is considerably older than him. She had three children from a previous relationship and they had a son together whom he continues to see approximately once a month. The relationship with Liz lasted three to four years. He is now divorced. He also has a daughter who he is not in contact with from a more recent relationship. He is no longer with the mother, who gave up their daughter for adoption. Prior to his current admission Leon had been supported by the West Fife Community Outreach Team. He had also had Richmond Fellowship support which was withdrawn. He was in receipt of DLA and Income Support but apparently had debts of around

£11,000. He was living alone in a council house. In terms of family psychiatric history, he has an aunt who suffers from agoraphobia.

Past Psychiatric History

At the age of seventeen Leon was referred by his GP to the Community Drugs Service with concerns about his benzodiazepine consumption. He DNA'd two appointments. In October 1992 he was re-referred. He attended on 29 October 1992 with his mother. At that time he was drug-free and it certainly did not appear to be a primary problem. It is noted that the fraught family conditions appeared to be more significant.

In March 1993, Leon was assessed at A&E after being brought by the police from a petrol station where he was shouting, swearing and disturbing the peace. He was thought to have consumed LSD, alcohol and ? Mephedrone tablets. On assessment, there was no evidence of mental illness and he was simply re-referred to the CDPS. He was later discharged from the CDPS in May 1993 due to non-attendance.

First admission – 12.09.93 to 26.01.94
Leon was admitted to the Royal Edinburgh Hospital after having been brought for assessment by his mother. His behaviour had given cause for concern over the preceding few days. He appeared frightened of people, was making odd remarks and was experiencing increased agitation. He was transferred to IPCU where he was commenced on Chlorpromazine and his mental state gradually improved. His behaviour required that he remain in IPCU for some time. His medication was changed to Trifluoperazine, he was transferred to a general ward and was discharged to Penumbra supported accommodation and referral to the Young People's Unit for follow-up. Diagnosis was acute psychotic episode.

Throughout 1994 and 1995, Leon attended the Young People's Unit in Edinburgh on a regular basis for review. He continued on Stelazine 25 mgs nocte. Towards the end of 1995 and the start of 1996 his attendance was sporadic but he appeared to remain well when taking medication and when free from psychosocial stress. The last letter from the Young People's Unit is from 10 April 1996.

Between 1996 and 1999 Leon does not appear to have had contact with the Psychiatric Services. In July 1999, while living in Lanarkshire, Leon was referred to the Psychiatric Services by his GP. He attended the outpatient clinic on 5 July 1999 with his wife at the time (Liz, who was a social worker). He presented with symptoms of a recent history of irrational fears (for example, that his wife and nine month old son may be kidnapped), paranoid ideas (people talking about him and laughing at him, calling his wife "a whore" and him "an eejit", and also "amnaesic episodes" where he wandered the area at night and with reduced awareness of surroundings. At that time it was unclear whether he had an underlying psychotic illness or not. The opinion was that he had a profound personality disturbance from his mid-teens which had been maintained and exacerbated by a continuing over-heated relationship with his mother, though the paranoid feelings were not thought to be psychotic. The episodes of wandering were more in keeping with some kind of dissociative state. He was advised to continue on the Stelazine and further outpatient review was arranged.

2nd admission – November 1999 to January 2001

Admission was arranged for a comprehensive ward-based assessment. Following the two and a half months inpatient stay, the diagnosis was of histrionic personality disorder and morbid jealousy state. There was little evidence to suggest a diagnosis of paranoid schizophrenia at that time. It was also mentioned that he had a fixed belief regarding his jealousy state and therefore it could also be described as a delusional disorder. He was discharged with outpatient and CPN follow-up on Olanzapine 10 mgs nocte.

In June 2001 he was assessed at Monklands A&E Department after having been brought in by his CPN following non-compliance with Olanzapine and Trazodone. He was complaining of nightmares, distressing memories of things that happened to him aged eighteen and experience of vague paranoid thoughts about former associates with whom he had previous illicit drug dealings that they may possibly be after him. At that time it was felt that he was experiencing a behavioural disturbance and lack of sleep with no evidence of psychotic disorder. His medications were recommenced. He was discharged to the previously in place outpatient and CPN follow-up.

By 2001, Leon had separated from his wife and was planning a move back to the Fife area. His care was transferred to the local sector area and a letter from the Lanarkshire consultant he stated that, although the possibility of schizophrenia had been raised, in his opinion the evidence pointed more towards gross personality dysfunction. Medications at that time were Olanzapine 10 mgs nocte and Sertraline 40 mgs daily.

By March 2002, Leon had engaged with the Fife area services and following consultant review in March 2002 it was thought his main issues were personality dysfunction with associated features. He was reviewed regularly by the Continuous Community Treatment Team.

3rd admission – 17.03.02 to 18.04.02

He was brought to his GP by the police after he had called the fire brigade thinking there was a gas leak. He had been non-compliant with his medications and had not slept for seven or eight days. He was complaining of auditory hallucinations and he presented in an agitated and confused state. He was commenced on Zuclopenthixol Decanoate depot and it was thought the form of his symptoms and pattern of his recovery remained consistent with a borderline personality disorder complicated by psychotic episodes.

He was followed up in August 2002 by a new consultant when the diagnostic impression was consistent with that of previous psychiatric assessments of personality disorder, although it was pointed out that there were features of his symptoms more consistent with a functional psychosis. Leon was placed on a Care Programme Approach and had regular review at outpatient clinics every three months. He also had weekly visits by a CPN and he was supported by Penumbra and encouraged to attend social groups, clubs and five aside football. In a letter dated February 2003 it states "**In view of his excellent response to medication, and in the context of previous diagnostic difficulties, it is looking increasingly likely that the correct diagnosis is schizophrenia rather than personality disorder**".

4th admission – 27.11.03 to 22.12.03
Leon was referred to the ward by the Community Outreach Team with a worsening of mood and increase in auditory hallucinations. He had also experienced suicidal thoughts and had impulsively taken a handful of Melatonin tablets to help him sleep prior to admission. He was also experiencing ideas of reference. On the ward his Clopixol depot was increased and he improved. He was discharged on Haloperidol 2 mgs qid, Zopiclone 15 mgs nocte and Zuclopenthixol Decanoate depot 250 mgs weekly. The diagnosis was schizophrenia. Follow-up continued as previous.

Throughout 2004 and 2005 he continued to be seen by the Community Outreach Team with CPA follow-up. He was referred for a neuropsychological assessment and had brief contact with a psychologist.

In October 2005 he was assessed at A&E after self-presenting with an overdose of five sleeping tablets and one Mirtazapine tablet. He described the trigger for the overdose was feeling agitated and angry. It was an impulsive act with no suicidal ideation therefore he was discharged with the regular follow-up.

In April 2006 he was assessed at Queen Margaret Hospital after the Community Outreach Team brought him in with worsening distress, paranoia, auditory hallucinations and suicidal ideation. He had taken a number of concealed overdoses recently. He was provided with additional prn antipsychotic medication and his intensive follow-up was continued.

In August 2006, at a Care Programme Approach meeting, he was noted to be engaging well with the Community Outreach Team, attending the gym regularly and engaging positively with the Occupational Therapy Department. He had seventeen hours of support per week from Richmond Fellowship. He was planning to start a drama course at college that month.

5th admission – 11.03.07 to 15.03.07
Leon was admitted to Rothes ward following an overdose of Loratadine. This was an impulsive act with no planning. He described worsening auditory hallucinations. His mood improved on the ward. He had apparently missed two doses of his depot prior to admission. It was felt that there were no new issues at that time and therefore discharge was arranged with his already in place follow-up.

In July he was reviewed at an outpatient clinic when he appeared to be psychotic, thought disordered and there were reports that he had been phoning ward 2 and the police in the middle of the night often in a threatening manner. In view of his agitation he was commenced on regular Diazepam and his depot of Flupenthixol was increased to 50 mgs weekly.

6th admission – 01.02.08 to 05.02.08
Leon had claimed to have taken an excessive amount of Co-codamol tablets. He was advised to attend A&E which he failed to do. When visited thereafter he was complaining of derogatory commanding hallucinations telling him to commit suicide. He had a disturbed sleep pattern and increased persecutory ideas. His mood was low. During his admission his depot was increased to Flupenthixol Decanoate 100 mgs weekly. He disclosed that he has experienced stressors

including an argument with his father and concerns with an upstairs neighbour. He was discharged with increased community support.

7th admission – 25.04.08 to 29.04.08
He was referred by the Community Mental Health Team with increased suicidal ideation and had been threatening to take an overdose of Valium, Paracetamol, slimming tablets and bleach. During his admission he talked about increased social stressors. Gradually the auditory hallucinations reduced in intensity and the suicidal thoughts dissipated. He was discharged with community follow-up.

8th admission – 08.06.08 to 27.06.08
Leon was admitted following an overdose of 16 Paracetamol tablets. His father phoned an ambulance after he disclosed his actions. There was no planning. He described feeling depressed in mood and he was admitted for further assessment. He described increased ruminations regarding a charge against his father for sexually abusing him and son which had been dropped and he was also thinking about another incidence of rape in his teens. His depot was increased to 150 mgs of Flupenthixol weekly which helped with the auditory hallucinations. Following a number of passes which went well he was discharged with follow-up.

In September 2009 he attended A&E in the company of police after calling them due to hearing someone trying to break into his house. There was no evidence of deterioration in mental state and he was discharged. Later in September he presented to A&E having taken an overdose of 4 Paracetamol and 4 Simvastatin tablets. He had fleeting suicidal ideation but no ongoing plans or intent and was therefore discharged with intensive follow-up.

In October 2009 he took an impulsive overdose of mixed high energy sports tablets in response to distressing hallucinations. He was reviewed the following day at the outpatient clinic and was commenced on a trial of Citalopram 20 mgs daily.

Leon was assessed in A&E in September 2010 following an overdose of twelve x 10 mgs Diazepam tablets. He attributed this to the stress of having split up with a partner in August 2010 as she has placed their baby up for adoption. He did not continue experiencing suicidal ideation and was therefore discharged home with support and reassurance, and follow-up.

Leon was assessed at Ward 8, Queen Margaret Hospital following a mixed overdose of Citalopram, Procyclidine and street-bought Diazepam. He described feeling low in mood. He stated he had tried to contact the Samaritans, however, was unable to get hold of them. He then contacted the Emergency Services himself. He denied any thoughts of self-harm or ongoing suicidal ideation therefore he was discharged with in place follow-up. He was due to attend the clinic for his depot the following day and he was to contact the consultant for outpatient appointment as previously planned.

9th admission – 09.04.11 to 25.04.11
Leon was brought to the psychiatric ward by the Outreach Team following a deterioration in his mental state due to illicit drug abuse. He had lost a lot of weight and appeared physically unwell. He was using amphetamines and Mephedrone and was spending around £250 per fortnight on drugs. He complained of insomnia and worsening of his psychotic symptoms. Following

admission to the ward Leon's mental state improved. He gained weight and passes went well without him abusing drugs.

10th and current admission – 08.09.11

Leon was admitted after the Community Outreach Team had concerns about his worsening mental state. Since the previous discharge in April 2011, Leon had been using amphetamines, ecstasy and cocaine on a regular basis and his lifestyle was generally more chaotic. He was not coping in his tenancy and his eating and sleeping patterns were poor. He was preoccupied with thoughts regarding "Paul Gilfillan" whom he stated was a paedophile and that he had "Madeline" who was abducted from Portugal. He described nightmares about being raped and said he spends his days "trying to find ways to keep children safe". He also was preoccupied with the delusion that his mother had only four years to live. Support workers had found him living in squalor. There was raw sewage in his garden and he had been eating from bins. Although he denied perceptual disturbance, the Community Outreach Team has witnessed him responding and he had also appeared thought-disordered. Leon was willing to accept informal admission. It was felt he would benefit from some time in rehabilitation given his diagnosis of schizophrenia and associated substance misuse with difficulty living independently in the community. A referral letter was sent in September 2011 and on 10 January 2012 he was transferred to Dunino rehabilitation ward.

Progress on Dunino

Following transfer to Dunino ward, Leon continued to voice delusional ideas and there was also evidence of perceptual disturbance. His mood was low at times and he was paranoid, occasionally making allegations against staff. Generally, however, he has settled into the ward and socializes with the other patients and staff. He continues to voice various delusions regarding "saving the children", drug dealers, Nazis. There has been evidence of auditory hallucinations and he has been observed laughing and talking to himself. He describes hearing voices which are mostly screams. He is paranoid about other patients stealing from him and can often lose track of his own conversation. On one occasion he was found in the corridor with wet floor cones in front of him which he stated was a barrier to paranoia. He manages to seek out staff. He describes feeling low in mood at times when he has thoughts about his past. He has appeared to become fixated with certain female staff members. He has also made allegations about staff, informing others that a staff nurse said he is "mad as a hatter". He also tore up letters from the DWP. He is sleeping reasonably well on the ward. He has been found smoking in his room on several occasions and has been advised against this. He often seeks one-to-one time with nursing staff. He is managing to eat well on the ward. He is able to shop independently, although has been lost trying to get back to the hospital due to the unfamiliar area. He has shown ability to cook easy meals. He manages to carry out his laundry independently but requires prompting to keep his area tidy, to budget and for self-care and self-catering. There have been no concerns about Leon while he has had time out in the community. He gets involved in ward activities and enjoys watching television with fellow patients. Leon has vocalized that he does not want to return to his house in Inverkeithing. He feels that people in the area are "after him" and he is concerned about becoming involved in the drug scene once again. A housing transfer has been applied for.

Medical History

Leon has had quite severe eczema in childhood. In August 2002 he described what sounded like paroxysmal tachycardia. He was referred for a twenty four hour ECG with no follow-up required. In June 2007 Leon attended his GP complaining of an episode of haematospermia and also intermittent fresh rectal bleeding. The GP at the time requested an opinion of the surgeons and also the urologist as to whether further investigation would be useful. (No further letters in the file). In October 2011, Leon was seen by a consultant general surgeon for his diagnosis of bilateral auxiliary hidradenitis. He was offered excision of the affected areas or a trial of antibiotics in the first instance which he preferred. For review in three to four months time.

Investigations

In September 2011 he had an ultrasound of testes. This was based on a clinical history of a small lump in the right epididymis. Ultrasound result was of normal appearances of both testes with no focal lesion evident. The tiny 4 mm cyst in the right epididymis is exophytic. Ultrasound of axillae on 01.12.11 showed bilateral enlarged axillary nodes. It was commented these may be reactive to superficial infection but other cause could not be excluded. **Recommendation to refer to the haematologist for further assessment.** In January 2012 ECG was normal except for rate, sinus bradycardia 58 bpm. An EEG in 2004 was reported normal. Recent blood tests including U&Es and LFTs on 15.12.11 were normal apart from a slightly elevated alanine transaminase of 59. Thyroid function tests in September were normal. A full blood count on 15.12.11 was normal apart from slightly elevated WBC, RBC, neutrophils, monocytes and Eosinophils. He is now under high dose monitoring and his blood tests will be repeated.

Forensic History

In May 2002 he was charged with breach of the peace. These charges were for sending very threatening letters to Falkirk Council regarding his ex-wife social worker. In August 2002 there was also an incident where he hit his mother was arrested and charged and received a deferred sentence. In a letter in August 2004 it was noted there had been a number of incidents whereby Leon had been verbally aggressive and two where he had been physically aggressive. The focus of the physical aggression has been his mother and a verbal aggression his mother and his ex-partner.

There is also note that Leon has made some sexually inappropriate comments to some members of staff at the Fife Community Outreach Team which had been some cause for concern. There is no further documentation regarding this. In July 2007 there was further note that Leon had been phoning Haldane House excessively and at times has said sexually inappropriate and disinhibited content.

There is also a note of a history of shop-lifting, however, there is no further information regarding this.

Drug and Alcohol History

Leon has quite an extensive history of alcohol and substance misuse. He was initially referred to the Community Drug and Alcohol Services in his late teens when there was concern about his illicit benzodiazepine use. In 1993 an acute psychotic episode causing admission appeared to be precipitated by him taken LSD. Between the ages of sixteen and eighteen he described using a lot of LSD, amphetamines and cannabis. From then on there was a history of intermittent substance misuse. This appeared to worsen prior to his most recent admission when he was thought to have been using ecstasy and cocaine on a regular basis. He denied previous IV drug abuse. He smokes cigarettes.

Current Medications

Nitrazepam – 10 mgs nocte.
Citalopram – 20 mgs mane.
Omeprazole – 20 mgs daily.
Pizotifen - 1.5 mgs daily.
Trifluoperazine – 10 mgs bd.

Dr Katy Johnson
Locum Speciality Doctor in Psychiatry

19 March 2012

Name Leon Grafton Mental Health Services

CHI/PIN No. FS158833 1703751191

Summary of Assessment *(General Overview of situation)*

Leon reports using amphetamines, esstacy, cocaine on regular basis. Takes food from bins of local bakers to eat. (Intimidated) by drug dealers. Has Tenancy issues Leaking sewage pipe. Can be over familiar with female staff Hence Joint visit at home. Previous Numerous Overdoses.

Recent physical altercation with a fellow patient. Leon was being verbally intimidated which resulted in said altercation. Has not been threatening to staff or other patients other than this lone incident.

Client involved Yes ☑ No ☐

Carer Involved Yes ☐ No ☑

Discussed with other agencies: please specify PTS

Comments: Other information obtained from previous documentation

**If required, please continue on a continuation/evaluation sheet*

Completed By: Bryan Clover Date: 8/9/4 Time: 1500

Need For More Detailed Risk Assessment & Management:

NO ☐ **YES** ☐ *If yes please go to RA part 2*

NHS Fife

Fife

Mental Health Services

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

Name: Leon Grafton Date of Birth: 17/03/75 CHI/PIN No:

Address: 85 Spittalfield Road Inverkeithing Post Code: KY11 1DZ Gender Male

Period/Date of Assessment: From 8/9/11 to 06/01/12.

Complete any details of identified Risk below:	Assessment (Circle relevant answer)
From Others (e.g. abuse, exploitation) Leon vulnerable to exploitation. Appears to be easily led by others. Previous association with drug dealers spending time in his home. Leon appear intimidated by same	No / Unknown / Yes
To Self (e.g. suicide, self harm) Impulsive behaviour. numerous overdose attempts. Use of illicit substances - admitting to use large quantities of ecstasy	No / Unknown / Yes
To Others (e.g. aggression, violence) Previously violent towards mother and step father Can be overfamilar towards females on home visits (WFCOT)	No / Unknown / Yes
Neglect (e.g. health, personal appearance) Reported on 5/11 had no bath for 6weeks, Dramatic weight loss,	No / Unknown / Yes
To Child(ren) (e.g. neglect, abuse) On 27/6/10 Reported by Barbara Barnes (child family social worker, that Leon had allegedly admitted to feeling sexually aroused around young children when he was younger 10+ years ago. Leon questioned by police no further action take	No / Unknown / Yes
Physical Impairment (e.g. medical, sensory)	No / Unknown / Yes
Wandering & / or Falls	No / Unknown / Yes
Memory and Cognitive Impairment (e.g. forgetfulness) Auditory hallucinations, command in nature. Overdose previously. impulsive behaviour. Daily dispensing medication	No / Unknown / Yes
Challenges to Services (e.g. inappropriate demands, poor compliance Has made false accusation towards others. Can be over familar with females. Sporadic attendance at depot clinic. Rarely attends O/P with Dr Cavanagh, Joint visits at home.	No / Unknown / Yes
Strengths/Positive Attributes (e.g. positive resources, agreed plans). Creative self publishe poetry, Creative writting	No / Unknown / Yes

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Medication History

For Period From 1993 To February 2012

Name: Leon Gratton	**Date of Birth: 17/03/1975** **CHI 1703751191**	**Unit no.:**
Date of admission: **Ward 2 QMH September 2001** **Dunino January 2012**	**Consultant: Dr Dasgupta**	**G.P:**
Ward / Address: **Dunino ward**	**Diagnoses: Schizophrenia, depression** **History of substance abuse**	

Current Drug Regime

a) Regular medication
Trifluoperazine 10mg bd
Citalopram 20mg in the morning
Nitrazepam 10mg at night
Paracetamol 1g qid
Pizotifen 1.5mg at night
Omeprazole 20mg in the morning

b) As Required Medication
Haloperidol 5mg oral up to qid
Maalox
Diclofenac 50mg bd
Soft paraffin
E45
Symptomatic relief
Bonjela

Summary (Medical / Medication)

Mr. Grattan has a long history. He was referred to young persons unit in Edinburgh aged 14 and 16 and was first admitted in 1993. The diagnosis of schizophrenia was reached relatively recently. In recent years he has self presented at A& E after overdoses. Use of cocaine ecstasy and amphetamines contributed to his most recent admission in September 2011. Sleep disturbance has been a prominent feature.

Medication	Maximum Dose Taken	Dates taken From/To	Comments
Trifluoperazine	25mg daily 20mg daily	1993-1996 2011	Good response Limited response
Olanzapine	15mg daily	2001-2002	
Zuclopenthixol dec	300mg 1/52	2002-2006	Some response but dose limited by EPSE
Haloperidol	10mg daily	2003-2005	In addition to depot
Flupentixol dec	150mg 1/52	2006-2011	Some response but dose limited by EPSE
Chlorpromazine	25mg bd prn	June 2010	
Sertraline	100mg daily	2001-2002	
Trazadone	300mg	2001	d/c due to concern that irregular heart

	nocte		rhythm may be side effect
Mirtazapine	15mg	2005-2006	Poor compliance
Citalopram	20mg	2006-2007 2009-? 2011- present	No details No details Since 2009?
Melatonin		2003	Night sedation
Zaleplon	10mg	2005	
Nitrazepam	10mg	2006-present	
Diazepam	15mg	various	

Treatment Options / Recommendations

Depending on response to recent increase of trifluoperazine the dose could be further increased to 30mg daily for a full trial.
Given the history of doses being limited by EPSE an atypical antipsychotic would seem a reasonable alternative. Limited information is available on previous exposure to olanzapine and no other atypical has been tried. Compliance in the community has been a problem so risperidone with a view to Risperdal Consta is certainly an option.
A full trial of olanzapine is another reasonable option.

In November 2011 the MHRA advised that citalopram should not be given with other drugs with potential to prolong QTc interval on ECG. This includes antipsychotics. Is an antidepressant still required? If so, Sertraline would seem a reasonable choice.

In the longer term Nitrazepam should be phased out.

Response to Pizotifen should be reviewed along with need for diclofenac prn.

Alyson Henderson, Senior Clinical Pharmacist 14/02/12

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Drug History

Date	Medication	Comments
1993-1999	Trifluoperazine up to 25mg daily	Admitted to Royal Edinburgh for 4 months in 1993- acute psychotic episode apparently precipitated by a bad LSD trip 2-3 weeks prior to admission. Psychotic symptoms settled after a couple of weeks Episode of paranoid ideas and visual hallucinations after stopping trifluoperazine for 2 months in 1997.
Jan 2001	Olanzapine	Discharged after being in hospital in Lanarkshire for two and a half months. Diagnosis histrionic personality disorder and morbid jealousy state.
April 2001	Olanzapine 10mg nocte Sertraline changed to trazadone which was increased to 300mg nocte	c/o chaotic sleep pattern .Hates sertraline.
June 2001	Olanzapine and trazodone recommenced	Deterioration- behavioural disturbance and lack of sleep- after 3 weeks non compliance with medication.
Sept 2001	Trazodone replaced by sertraline	c/o irregular heart rhythm; irregular pulse. ? adverse effect of trazodone.
Oct 2001	Olanzapine 10mg nocte Sertraline 100mg daily	Moved to Fife
Dec2001	Olanzapine 10mg Sertraline 50mg Diazepam 2mg	Short course of diazepam for anxiety
March 2002	Olanzapine increased to 15mg	No evidence of psychosis – borderline personality, prone to dissociative reactive states and paranoid ideation
March - April 2002	Olanzapine phased out Zuclopenthixol commenced and increased to 200mg 2/52 Sertraline 50mg daily	6 week admission to QMH ward 2. Initial presentation in agitated and confused state, c/o auditory hallucinations. Considered to be borderline personality disorder complicated by psychotic episodes
Aug 2002		Persistent nocturnal paroxysmal tachycardia and at least one episode of tachycardia with irregular pulse. 24 hour ECG requested
Dec2002	As above Zopiclone short term	Doing reasonably well
Feb 2003	Depot increased	Improvement since depot increased. "Diagnosis more likely to be functional psychosis"
May 2003	Procyclidine prn	Doing very well. C/O "shakes". Later reported that procyclidine resulted in agitation.
Aug 2003	Melatonin as night sedation	
Nov –Dec	Discharge medication	1/12 Admission to ward 2. Worsening of

2003	Zuclopenthixol dec 250mg 1/52 Haloperidol 2mg qid Zopiclone 15mg nocte	mood; poor sleep often waking up due to auditory hallucinations; poor appetite; suicidal thoughts and impulsive overdose of melatonin. Had taken cannabis in previous week. Requested increase in depot and change to night sedation. Settled after a few weeks on ward
May 2004		Reasonably well apart from sleep difficulties and hypnogogic hallucinations. For EEG
13/08/04	Haloperidol 5mg bd prn Orphenadrine 50mg tid Zuclopenthixol 250mg 1/52	Worsening in auditory hallucinations. EPSE evident. Unwilling to increase depot as feels oversedated. Much less troubled by hallucinations after haloperidol commenced.
24/08/04	Zuclopenthixol increased to 300mg 1/52 Haloperidol 5mg bd Orphenadrine 50mg tid	Agreed to increase in depot.
Oct 2004		Improvement with increase in depot. Haloperidol now only prn. Still doing well in December apart from sleep pattern.
April 2005	Mirtazapine 15mg at night	Low mood; lack of sleep; possible EPSE. Did not take mirtazapine
May 2005	Zuclopenthixol reduced to 250mg 1/52 Mirtazapine 15mg at night Zaleplon 10mg at night	Depot reduced due to EPSE. Sleep/wake cycle remains poor; team don't feel that he is particularly depressed
Oct 2005		Self presented at A&E following overdose of 5 Zaleplon and 1 mirtazapine. Said trigger was "just agitation".
Dec 2005	Trifluoperazine 2mg prn instead of haloperidol	Worsening of night time auditory hallucinations. Does not want to increase depot. Trifluoperazine worked well previously.
March 2006	Nitrazepam	Reasonably well. Sleeping better with Nitrazepam but some hangover tiredness. Main concern is tremor. He does not like procyclidine or orphenadrine. Tremor improves after taking Nitrazepam- may be exacerbated by anxiety.
April 2006	Zuclopenthixol 300mg 1/52 Nitrazepam Mirtazapine (poor compliance) Haloperidol prn supplied	Increased distress, paranoia, auditory hallucinations and suicidal ideation. Assessed at QMH and discharged.
May 2006	Depot changed to flupentixol	No psychotic symptoms but EPSE and feels zuclopenthixol no longer suiting him.
Aug 2006	Depot Reduced to fortnightly	Sleep/wake cycle poor but fewer EPSE since depot reduced
Nov 2006	Depot increased	
Dec 2006	Flupentixol dec 60mg 2/52 Citalopram 20mg daily (when started?) Nitrazepam 5mg at night	Improvement after depot increased
March 2007	Flupentixol 30mg 1/52 Ranitidine 150mg bd Nitrazepam 10mg nocte Loratadine 10mg daily prn	Self-presented at A&E after impulsive overdose of loratadine. Had missed 2 doses of depot. Discharged after a few days

	No longer on citalopram	
July 2007	Flupentixol increased to 50mg 1/52 Diazepam 5mg tid	Psychotic- thought disordered and paranoid. Improvement after increase.
01/02/08-05/02/08	Flupentixol increased to 100mg 1/52 Nitrazepam 10mg at night Diazepam 6mg daily	4 day admission. Claimed to have taken excess co-codamol but paracetamol levels did not require treatment. C/O derogatory command hallucinations and persecutory ideas. Depot increased
25/04/08-29/04/08	Diazepam now 5mg daily	Further admission. Had been less well over past 6-8 weeks. More anxious, hearing voices, paranoid
08/6/08-27/06/08	Flupentixol increased to 150mg 1/52 Nitrazepam 10mg at night	Admitted following overdose of 16 paracetamol.
Aug 2008	Chlorpromazine 25mg bd prn	Hearing "screaming".
Sept **2009**	Flupentixol Nitrazepam Diazepam Chlorpromazine	Assessed twice in few weeks by Psychiatric Assessment Service and discharged home.
Oct 2009	Flupentixol dec150mg 1/52 Nitrazepam 10mg nocte Citalopram 20mg daily commenced	Assessed by Psychiatric Assessment Service after overdose of high energy sport tablets Persistent, pervasive low mood, anergia and anhedonia. Hearing voices 2-3 times weekly.
Nov 2009	Flupentixol dec150mg 1/52 Nitrazepam 10mg nocte Citalopram 20mg daily Diazepam 5mg daily Trihexyphenidyl 1mg daily increase to 2mg after 1/52	Mental state largely stable- hallucinations a few times each week. Fine tremor. No akathisia, dystonia or tardive dyskinesia. Procyclidine previously no benefit and "caused hallucinations" Orphenadrine helped symptoms but gave him nightmares.
June 2010	Chlorpromazine 25mg bd prn	Very stressed somatic symptoms; hearing screams.
Sept 2010		Self- presented at A&E after overdose of 12x 10mg diazepam.
Nov 2010	Flupentixol dec Diazepam Nitrazepam Trihexyphenidyl	Assessed by Psychiatric Assessment Service after mixed overdose of citalopram, procyclidine, diazepam (street bought)
09/04/11-25/05/11	Citalopram 20mg Nitrazepam increased from 5 to 10mg daily Trihexyphenidyl 2mg in the morning Flupentixol 150mg 1/52	Admitted for 2 weeks – taking amphetamines and mephedrone, loosing weight, not sleeping. Mental state remained settled on ward and physical health improved.
Sept 2011	Flupentixol d/c Trifluoperazine commenced & increased to 5mg bd Omeprazole 20mg	Admitted due to deterioration in mental state. Using cocaine, ecstasy and amphetamines on regular basis. Last depot 26/05/11? Not keen for depot due to EPS
Nov 2011	Trifluoperazine increased to 15mg daily Pizotifen 1.5mg nocte	Feels increased trifluoperazine helped. Headache improved with pizotifen but later c/o headaches.
Jan 2012		Transferred to Dunino ward for rehab.
Feb 2012	Trifluoperazine increased to 10mg bd	

****
*** TX REPORT ***
****

TRANSMISSION OK

TX/RX NO	0296
RECIPIENT ADDRESS	901592265967
DESTINATION ID	
ST. TIME	24/08 15:28
TIME USE	00'29
PAGES SENT	3
RESULT	OK

Fax

NHS Fife

CONFIDENTIAL - URGENT

To	Dr Sharon Cullinane Associate Specialist in Rheumatology	**Fax**	01592 265967
From	Dr Sandip Datta Locum Specialty Doctor	**Date**	23 August 2012
Re	Leon Gratton 1703751191	**Pages**	3 (including front sheet)

☐ For information

☐ Please comment

Fax

NHS Fife

CONFIDENTIAL - URGENT

To	Dr Sharon Cullinane Associate Specialist in Rheumatology	**Fax**	01592 265967
From	Dr Sandip Datta Locum Specialty Doctor	**Date**	23 August 2012
Re	Leon Gratton 1703751191	**Pages**	3 (including front sheet)

☐ For information

☐ Please comment

Kirkcaldy & Levenmouth CHP
Mental Health Service

Medical Offices
Stratheden Hospital
CUPAR
Fife
KY15 5RR
Tel: 01334 652611
Fax: 01334 696042

NHS Fife

PRIVATE & CONFIDENTIAL

Dr Sharon Cullinane
Associate Specialist in Rheumatology
Department of Rhematology
Victoria Hospital
Kirkcaldy

Date Typed: 23 August 2012
Your Ref:
Our Ref: SD/MT/SF5153833A

Enquiries to: Margaret Thomson
Direct Line: 01334 696362
Internal ext: 56362
E-mail: m.thomson5@nhs.net

Dear Dr Cullinane

By Fax 01592 265967

Leon Gratton, 85 Spittalfield Road, Inverkeithing, KY11 1DZ
CHI – 1703751191
Currently care of Dunino Ward, Stratheden Hospital

I would be grateful for your opinion on the above patient. Mr Gratton is currently in inpatient on Dunino Rehabilitation Ward at Stratheden Hospital. He has a long history of schizophrenia and drug misuse and depression. His current admission began in September 2011. He was admitted to Ward 2 at queen Margaret Hospital

With respect to his medical history Leon had quite severe eczema as a child. In August 2002 he described what sounded like paroxysmal tachycardia. He was referred for a 24 hour ECG with no follow up required. He was also seen in October 2011 by a general surgeon for his bilateral axilliary hidradenitis. He was offered excision of the affected areas but a trial of antibiotics in the first instance had good effect. Leon continues to complain of multiple stiffness and joint pain which has been worse in the morning for a number of months. He has been using Paracetamol regularly which relieves the pain on occasion. However he continues to ask for further analgesia but is unable to take Ibuprofen because of stomach problems.

Mr Gratton had an appointment to see yourself on the 24th of May, however there was a mix up with his hospital transport and therefore he was unable to attend.

His current medication list includes Omeprazole 20mg in the morning, Pizotifen 1.5mg at night, Rose Fraser Cream once in the morning, Clozapine 100mg once daily, Hyoscine Hydrobromide 300 mcgm twice daily, Clozapine 225 mg in the evening, Sertraline 50mg in the morning, Laxido one sachet once daily.

☐ Original
☑ Case notes
☐ Nursing notes
☐ Medical office
☐ Medical records

I would be grateful if you could send another appointment for Mr Gratton.

Please do not hesitate to contact me if you require any further information.

Kind regards.

Yours sincerely

Dr Sandip Datta
Locum Specialty Doctor

TELEPHONE MESSAGE

TO	**Pritha**
FROM	**Mrs Gratton**
Phone	**077 6260 2112**
DATE	**18.06.12**
REGARDING	**Mrs Gratton telephoned asking if you would return her call. Her son Leon has been phoning her and these calls have been causing her quite some distress. Some of Leon's comments had been very personal.**

18/6/12 → T/C made. Spoke to Leon's mum. She wanted to come & have a meeting with me & Leon. According to her the purpose of the meeting is about benefit & Leon's taking more responsibility about things. I advised her it might not be right time for the dealing with financial & social issues because she is needing more medical attention. She claimed that Leon's phone call is affecting her health. I tried to explain it might be because he is unwell & it would be best not to make any phone call for the time being. She appeared being emotional & angry and put the phone down.

P. Dashgupta

P. DASHGUPTA
Consultant.

Kirkcaldy & Levenmouth CHP
Mental Health Service

Medical Offices
Stratheden Hospital
CUPAR
Fife
KY15 5RR
Tel: 01334 652611
Fax: 01334 696042

NHS Fife

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Dr S Cullinane, Associate Specialist in Rheumatology
Victoria Hospital
Hayfield Road
KIRKCALDY
KY2 5AH

Date Dictated: 15 May 2012
Date Typed: 15 May 2012
Your Ref:
Our Ref: SD/MT/SF5153833A

Enquiries to: Margaret Thomson
Direct Line: 01334 696362
Internal ext: 56362
E-mail: m.thomson5@nhs.net

BY FAX – 01592 265967

Dear Dr Cullinane

Leon Gratton, C/o Dunino Ward, Stratheden Hospital, Cupar, KY15 5RR
CHI – 1703751191

I would be grateful for your opinion on the above patient. Mr Gratton is currently a patient in Dunino rehabilitation ward at Stratheden Hospital. He has a long history of schizophrenia, drug misuse and depression. His current admission began in September 2011 when he was admitted to Ward 2 at Queen Margaret Hospital. With respect to his medical history, Leon had quite severe eczema as a child. In August 2002 he described what sounded like paroxysmal tachycardia. He was referred for a twenty four hour ECG with no follow-up required. He was also seen in October 2011 by a general surgeon for his diagnosis of bilateral axillary hidradenitis. He was offered excision of the affected areas but a trial of antibiotics in the first instance which he preferred. Leon has been complaining of multiple stiffness and joint pain which has been worse in the morning for a number of months. He has been using Paracetamol regularly which relieves the pain on occasion. He continues to ask for further analgesia but is unable to take Ibuprofen because of stomach problems.

Current Medication
Nitrazepam – 10 mgs at night.
Omeprazole 20 mgs in the morning.
Sertraline – 50 mgs in the morning.
Risperidone – 2 mgs in the morning and 3 mgs at night.

He continues to use symptomatic relief Paracetamol, although on occasion does use Ibuprofen. He complains of pain in both elbow joints as well as his knees but especially in the cervical spine. On examination, there is no swelling or redness. Physically his obs. are within normal range. I would be very grateful for your opinion on Mr Gratton. Please do not hesitate to contact me if you require any further information. Kind regards.

Yours sincerely

Dr Sandip Datta
Locum Specialty Doctor

POSITIVE ABOUT DISABLED PEOPLE

☐ Original
☑ Case notes
☐ Nursing notes
☐ Medical office
☐ Medical records

Victoria Hospital
Hayfield Road
Kirkcaldy
Fife
KY2 5AH

Department of Haematology
Tel: 01592 643355 Ext 29484 -
Meg Ross
http://www.nhsfife.scot.nhs.uk

NHS
Fife

Dr Sandeep Datta
Locum Specialty Doctor
Stratheden Hospital
CUPAR
Fife
KY15 5RR

CLINIC LETTER

1703751191

CHI: 1703751191
Hospital ID: V700828K

Letter ID: 214428

Dear Dr Datta

Clinic Date: 14/05/2012

Date: 15/05/2012

Leon Gratton, C/O Dunino Ward, Stratheden Hospital, Cupar, Fife, KY15 5RR
Date of Birth: 17/03/1975

Thanks for your note about this patient who I saw in clinic today with concerns about swellings in his axillae. These haven been a problem on and off for several months usually accompanied by a crop of small boils in the axilla. Ultrasound has shown small lymph glands no more than 4mm or 5mm in diameter and a biopsy has shown reactive changes only. In addition to the axillary problems he complains of pain in most parts of her body, particularly chest and abdomen and pain in passing urine. He has no cough or sputum production. He is smoking about half an ounce of tobacco a day.

Current Medications

Nitrazepam 10mg at night, Omeprazole 20mg per day, Pizotifen 1.5mg at night, Paracetamol prn, Trifluoperazine 15mg x bd and Sertraline 50mg per day. He has recently smoked and swallowed drugs of abuse but never injected.

Allergies

Nil.

He is currently an in-patient at Stratheden for rehabilitation.

On examination, he was clearly anxious about his symptoms. He was tender in both axillae with a number of scars in the skin and some pea-sized lymph nodes, particularly on the right. There was no other peripheral lymphadenopathy and no positive findings in the chest or abdomen. He's had a recent normal full blood count and biochemistry.

SD
22/5.

I think these must be reactive nodes from his superficial boils in the axilla and I really don't think further investigation is required here. He is clearly anxious about a number of physical symptoms but I suspect this is all part of his psychiatric state and I don't think it would be indicated or wise to pursue further investigations at this stage.

Best wishes.

Yours sincerely

Dr Peter J Williamson
Consultant Haematologist

Authorised on 16/05/2012 11:13:08 by Typist Meg Ross, on behalf of P Williamson.

(P) Dr DM Taylor, Inverkeithing Medical Centre, 5 Friary Court, Inverkeithing, Fife, KY11 1NU

****
*** TX REPORT ***
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TRANSMISSION OK

TX/RX NO	4782
RECIPIENT ADDRESS	28055
DESTINATION ID	
ST. TIME	18/04 13:25
TIME USE	02'53
PAGES SENT	5
RESULT	OK

NHS Fife

Kirkcaldy & Levenmouth CHP
Mental Health Services

Personal/Patient Information – Medical Confidential

To: Dr Williamson, Haematology Dept, VHK	**Fax No:**	**01592 648055**
From: Dr S Datta, Locum Speciality Doctor, Stratheden Hospital, Cupar	**Fax No:**	01334 696042
Date: 18 April 2012		**No. of Pages(including this page) 5**

Subject: Referral for - LG

If you have any difficulties in reading this please telephone:
01334 696362

Ask for: **Margaret Thomson**

Please call me back to let me know you have received this fax.

□ urgent

□ for information

□ please comment

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Kirkcaldy & Levenmouth CHP
Mental Health Service

Medical Offices
Stratheden Hospital
CUPAR
Fife
KY15 5RR
Tel: 01334 652611
Fax: 01334 696042

NHS Fife

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Dr Williamson
Haematology Department
Victoria Hospital
Hayfield Road
KIRKCALDY
KY2 5AH

Date Dictated: 18 April 2012
Date Typed: 18 April 2012
Your Ref:
Our Ref: SD/MT/SF5153833A

Enquiries to: Margaret Thomson
Direct Line: 01334 696362
Internal ext: 56362
E-mail: m.thomson5@nhs.net

Dear Dr Williamson

Leon Gratton, C/o Dunino Ward, Stratheden Hospital, Cupar, KY15 5RR
CHI – 1703751191

I would be very grateful for your opinion on the above patient, Mr Gratton. He is currently an inpatient in Dunino rehabilitation ward at Stratheden Hospital. He has a diagnosis of schizophrenia and borderline personality disorder, and he has taken overdoses in the past.

With regard to his past medical history, he suffered from weight loss and tremors and also has a diagnosis of hidradenitis suppurativa. Late last year Mr Gratton had some superficial axillary masses which were red and tender, therefore an ultrasound scan of both axillae was conducted. The scan showed bilateral enlarged axillary nodes, cortex measuring 4 mm on the right and 4.5 mm on the left. It was concluded that this may be reactive to superficial infection and a more sinister cause could not be excluded, therefore it was suggested that a referral to Haematology may be worthwhile. However, in March of this year he was seen by the surgical team who did a biopsy which confirmed reactive changes compatible with a history of chronic infection and hidradenitis suppurativa. As can be seen from the letter enclosed it was decided that there was no further investigation planned. I would be very grateful for your advice regarding this patient.

His current medication includes:

Nitrazepam – 10 mgs at night.
Omeprazole – 20 mgs in the morning.
Pizotifen– 1.5 mgs at night.
Paracetamol – 1 gm four times a day.
Trifluoperazine liquid – 15 mgs twice a day.
Sertraline – 50 mgs once in the morning.

☐ Original
☒ Case notes
☐ Nursing notes
☐ Medical office
☐ Medical records

18 April 2012

I would be very grateful for your opinion and advice regarding this patient. Please do not hesitate to contact me if you require any further information.

Kind regards.

Yours sincerely

Dr Sandip Datta
Locum Specialty Doctor

Queen Margaret Hospital
Whitefield Road
Dunfermline
Fife
KY12 0SU

Breast Services
Tel: 01383 623623 Ext 2 3701
http://www.nhsfife.scot.nhs.uk

NHS
Fife

Dr F Williams
Psychiatry Dept
Queen Margaret Hospital
Dunfermline

ADMINISTRATIVE LETTER

1703751191

CHI: 1703751191
Hospital ID: D659366L

Letter ID: 153658

Date: 09/03/2012

Dear Dr Williams

Leon Gratton, 85 Spittalfield Road, Inverkeithing, Fife, KY11 1DZ

Date of Birth: 17/03/1975

I reviewed the result of needle aspiration of this gentleman's left axillary node which has confirmed reactive changes which is compatible with his history or chronic infection and hidradenitis suppurativa. This was discussed in our MDT meeting where it was decided no further investigation or treatment is planned.

I am therefore happy to discharge him from our clinic back to your care.

Yours sincerely

Ir H Ahmad
Staff Grade Surgeon

Authorised on 09/03/2012 14:30:19 by Typist Jean Lowes, not verified by Consultant.

(P) Dr D Somerville, Inverkeithing Medical Group, 5 Friary Court, Inverkeithing, KY11 1NU

SCI Store - Patient Result Report

Report ID: E-04016690

Fife SCI Store Live

Sample Collected: 06/12/2011 14:46:00

Patient

Patient Name	CHI	Date Of Birth	Age	GP	GP Practice	Consultant	Ward/Location
LEON GRATTON	1703751191	17/03/1975	36	GARMANY, DAVID	INVERKEITHING MEDICAL CENTRE	CAVANAGH, P	(Q2) Ward 2 QMH

Report Details

Report Requestor	Requestor Location	ReportIdentifier	Discipline	Referral Source
Joseph, CAVANAGH, Paul	(F805HBCQ) QMH BREAST CLINIC	E-04016690	Radiology	N/A

Sample Type	Sample Collected	Sample Received	Processed Into Store
IMAGING	06/12/2011 14:46:00	08/12/2011 11:30:06.987	08/12/2011 11:32:09

Report

US Axilla Both

Leon Gratton

Clinical Information: Bilateral superficial axillary masses. Red and tender on the left. ? abscesses. Known hidradenitis suppurativa.

ULTRASOUND BOTH AXILLAE:

There are bilateral enlarged axillary nodes. Cortex measures 4 mm on the right and 4.5 mm on the left. These may be reactive to superficial infection, and the patient does mention that he probably has groin masses as well, but a more sinister cause cannot be excluded (? haematological)

CONCLUSION:

U3. Please refer to the haematologist for further assessment.

Reported by: SHARMA, Ashwini Dr

Verified by: SHARMA, Ashwini Dr

Printed By: fionnuala williams on 08/12/2011 14:14:06

Queen Margaret Hospital
Whitefield Road
Dunfermline
Fife
KY12 0SU

Breast Services
Tel: 01383 623623 Ext 2 3701
http://www.nhsfife.scot.nhs.uk

NHS
Fife

Dr F Williams
Psychiatry Dept
Queen Margaret Hospital
Dunfermline

ADMINISTRATIVE LETTER

1703751191

CHI: 1703751191
Hospital ID: D659366L

Letter ID: 153658

Dear Dr Williams

Date: 09/03/2012

Leon Gratton, 85 Spittalfield Road, Inverkeithing, Fife, KY11 1DZ

Date of Birth: 17/03/1975

I reviewed the result of needle aspiration of this gentleman's left axillary node which has confirmed reactive changes which is compatible with his history or chronic infection and hidradenitis suppurativa. This was discussed in our MDT meeting where it was decided no further investigation or treatment is planned.

I am therefore happy to discharge him from our clinic back to your care.

Yours sincerely

Mr H Ahmad
Staff Grade Surgeon

Authorised on 09/03/2012 14:30:19 by Typist Jean Lowes, not verified by Consultant.

(P) Dr D Somerville, Inverkeithing Medical Group, 5 Friary Court, Inverkeithing, KY11 1NU

Kirkcaldy & Levenmouth CHP
Mental Health Service

Medical Offices
Stratheden Hospital
CUPAR
Fife
KY15 5RR
Tel: 01334 652611
Fax: 01334 696042

NHS Fife

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Mr S Bennett, Consultant Surgeon
Department of General Surgery
Victoria Hospital
Hayfield Road
KIRKCALDY
KY2 5AH

Date Dictated: 21 February 2012
Date Typed: 21 February 2012
Your Ref:
Our Ref: SD/MT/SF5153833A

Enquiries to: Margaret Thomson
Direct Line: 01334 696362
Internal ext: 56362
E-mail: m.thomson5@nhs.net

Dear Mr Bennett

Leon Gratton, 85 Spittalfield Road, Inverkeithing, KY11 1DZ
CHI – 1703751191

Thank you for your letter dated 8 February 2012. The patient named above has actually already been seen by your team had biopsies taken for axilliary hidradenitis. There was some mix-up of where the original clinic letter was sent. Please do not hesitate to contact me for further information.

Kind regards.

Yours sincerely

Dr Sandip Datta
Locum Specialty Doctor

POSITIVE ABOUT DISABLED PEOPLE

☑ Original
☑ Case notes
☐ Nursing notes
☐ Medical office
☐ Medical records

Queen Margaret Hospital
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NHS
Fife

Dr F Williams
Psychiatry Dept
Queen Margaret Hospital
Dunfermline

CLINIC LETTER

1703751191

CHI: 1703751191
Hospital ID: D659366L

Letter ID: 100184

Dear Dr Williams

Clinic Date: 10/01/2012

Date: 12/01/2012

Leon Gratton, 85 Spittalfield Road, Inverkeithing, Fife, KY11 1DZ

Date of Birth: 17/03/1975

Thanks for referring this gentleman to the breast clinic with bilateral axillary lumps. He has only started medication for schizophrenia and has had surgery in both arm pit and groin for possible hydradenitis suppurativa.

On examination I could not feel any lump in either breast but there were a few small lymph nodes palpable in both axillary areas but not in supraclavicular fossa.

I have explained to him that the nodes might be reactive to the infection that he has had and I have requested an ultrasound guided FNA to be done as an outpatient. We will write to you with that result.

Yours sincerely

Hamid

Mr H Ahmad
Staff Grade Surgeon

Authorised on 12/01/2012 14:31:06 by Typist Jean Lowes, not verified by Consultant.

(P) Dr David Somerville, Inverkeithing Medical Group, 5 Friary Court, Inverkeithing, Fife, KY11 1NU

~~6/12/11~~

7/1/12

WR Cavanagh

Still c/o headaches.
Saw son x 2 over festive period.
Nervous re transfer to rehab →
Advised to view this positively

(P) Stop prozilen
T/F to rehab in 6/1/12

WILLIAMS
CT1

7/1/12

09:10

Called Denise Ward

Made aware of OPD appt at QMH on 10/1/12 at 2-30pm.

WILLIAMS
CT1

10.1.2012

Transferred from QMH

Δ ① Schizophrenia
② Drug misuse
③ Depression
④ Borderline PD

Plan
- continue medication
- Review in WR on 7th

SS
DENISE EASON

Nursing: for 6/52 assessment & 2/52 passed.
- Review on 16-2-2012 @ 11-30 AM.
- Hears voices → requests PRN Haloperidol
- deluded about his mother
- He grew a beard + his mother was concerned that he broke the sewage pipe - Has residual psychotic symptoms.
- He is smoking in the room + gave to other patients

OT: for initial assessment this morning

Interview
- more peaceful and likes lying down as there's a lot of things going in his mind.
- Paedophile Ring when he was in Edinburgh and there was a lot of homophobia and racial tension in the area.
- Mother is working in this area now
- She has always been bad
- Drug scene is nice but there are a lot of drugs "Heroin and the rest" in the area. He used drugs but no cravings now.
- Madeleine McCann appears in his mind regularly
- He was raped once and there is a lot of rapes going on.
- His mother was molested by her dad. "I blamed to kill him, but he is dying of lung cancer and heart disease now."
- "There are a lot knives and guns in the area and a lot of fighting"
- used to have messages from TV and radio, but not any more - but hear a lot of screaming.
- "They tried rat poison on me" Mother also did it, & SIL molested me when I was young
- Depot was changed because he was taking piriton to get
- Has pain and headache hence Paracetamol
- advised to attend OT sessions
- advised not to smoke on the ward

Plan
- Trifluoperazine 10mg BD

SE

16/2/12 WR and 6 weeks review
No body from community team
(D Nursing → Delusion existing.
Evidence of responding to hallucination.
Paranoid to other people (stopped)
Mood - low at time when talks about past-

Allegation against staff
Want for appt for under the arm problem —
Gets exploited by others.
Needs prompting for budgeting, self care and self catering
(Detailed in nursing report)

(B) Leon came within bounds (smoking) & stayed.
Leon stated that he is doing well, happy to continue working here
Mother brought in photos of his property (all beautifully cluttered)
Troubled by drug dealers.
House is still Leon's, mum can put in an application to transfer it.

PLAN - (1) Leon to continue rehabilitation.
(2) ECT (he is on citalopram) Dose of Trifluoperazine has been increased,
(3) High dose monitoring.

29/3/12 WR

Nursing → Same presentation with residual psychotic symptoms.
Engaging well in self catering
→ motivators
Using PRN Bonjela regularly
Willing to engage.

Not much benefit from increased dose of Trifluperazine.

QTc interval has been increased.

Diastolic blood pressure ↓

Has remained.

Has tablets increased dose of Stelazine then helped with voices — not distressed

Frequency of nightmares has been decreased.

Feels safe here.

Feels can manage medication

Despite of voices

C/O painful joints in extremities

using Brufen as required.

Abscess are better.

PLAN - ① Continue with current medication.

② ECG

③ Referral to Rheumatologist.

④ High dose monitoring

PRN Haloperidol

P. DASGUPTA.

Has asked for Lorazepam.

It has been discussed in MDT that he responds well to 1:1 not needing PRN Haloperidol.

Verbal de-escalation would be given

plan because of his H/O

~~pain~~ abuse

Surname GRATTON	Unit No.
First Names LEON	Date seen or Admitted
Maiden Surname	Seen at
Address	Seen by
	Consultant in Charge
	Family Dr.
	Referred by

D. of B. Sex M. F. M.S.W.D. Religion Occupation

13/12 UR DR DASGUPTA

Nursing staff state that Leon continues to have delusions and has alot of psychosomatic symptoms. Leon states that "this his mouth "has been up and down." He states he continues to hear voices, and his mood has been in low in the morning.

(P) (i) Olanzapine increase to 5mg.

(ii) Leon would like to join gardening group with OT.

DASG.

9/4/12 UR DR DASGUPTA

Nursing - remains deluded, sleeping for long periods through the day. Regularly seeking analgesia but not for any specific pain. Leon continues not to engage with OT. Leon feels he is overdosed with trifluoperazine.

patient - Leon was courtesy not on the ward.

(P) (i) Stop regular paracetamol.

(ii) Reduce trifluoperazine to 10mg BD and introduce respridone to long write.

DASG.

8/5/12 Received with Mezine

Leon reported that he is feeling better on Risperidone. Voices are less distressing & less in amount.
~~Deluded~~ - Persecutory ideas about his mum.

c/o Pain in ~~the~~ 3 multiple joints stiff in the morning relieved by paracetamol. ~~He~~ He is still suffering from ~~it~~ unable to take Bonjela because problem in stomach

PLAN 1 - Refer to rheumatologist for opinion.

P. DASGUPTA

9/5/12

DR DASGUPTA

Nursing - very thought disturbed, chaotic, unsettled requiring analgesia. Complaining of multi joint pain. Sleeping has been unstable, having graphic thoughts and having nightmares.

OT - not engaging with OT. Leon is quite paranoid about his mother. Leon states he is too tired to engage with OT. He has stopped going to the garden because he does not feel safe.

P) (i) Refer to rheumatology.
~~(ii) botox every 3 months~~
(ii) ↑ Aripiprazole to 2mg mane + 3mg nocte

7/5/12

WARD REVIEW

Nursing - States there have been deterioration in mental state with increasing ↑ in psychotic symptoms.

P) ↑ Aripiprazole to 5mg daily.

NAME LEON GRATTON.	Continuation Sheet No.	Unit No.

24/5/12 Reviewed

Focussed on somatic problems. (nodule under the arm to polyp in the throat).
Reported feeling slightly worse on Risperidone.
Discussed about clozapine — told me he had it before — horrible side-effect — like a dry mouth. (?).
Agreed to give it a try if ~~there~~ Risperidone doesn't help.
Reviewed blood result up to 2008 on SCI-store — no evidence of ↓ WBC count.

P DASGUPTA

31/5/12 UR DR DASGUPTA

Nursing — continues to be vague and is still struggled with his mental state.

(P) Continue with Tx plan.

7/6/12 WARD REVIEW DR DAS GUPTA

Leon states that sometimes he feels ok but sometimes in the morning he feels depressed.
Leon is happy to consume clozapine, and all the SIE have been explained to Leon.
(P)
(i) Commence Clozapine titration on 8/6/12
(ii) Reduce upside to 2mg BD.

11/6/12 Reviewed

c/o having 'rough time' during change over from Risperidone to clozapine.
Feeling dizzy when getting up.
Preoccupied with debts ie 'shutting down' his existing home & putting money back to his account. He wants to live either in Glenrothes, Cupar or Springfield.

PLAN: ① Sitting, standing BP — dizzy drop of systolic BP 7 20mm Hg.
Consider reducing dose of Risperidone by 1mg.
② Referral to social worker about possible travel Grant

P. DASGUPTA
consultant

14/6/12
Discuss with Pharmacist who feels it would be ok to ↓ her risperidone as his clozapine is increasing. Pharmacist is currently having no effect from the clozapine.
① ↓ Risperidone to 1mg BD.

[signature]

18/6/12 Reviewed

Pharmacist c/o feeling dizzy. ② No postural drop in BP. Pulse ranging from 110 — 122.
Admits ② no psychotic symptoms. Feels slightly better. ~~Not~~ did not sleep very well last night, hasn't ~~not~~ slept till now.
~~Agr~~ Discussed about argument with mother on phone. Agreed following plan; —

NAME Sean Grattan.	Continuation Sheet No.	Unit No.

(1) Reduce dose of Risperidone by 1mg
(2) Now If dizzyness increases or V/Ts becomes unstable delay increasing dose of clozapine.
(3) Escorted to town to minimize risk of to his physical health & to his mother.
(4) Sean agreed not to make phone call to his mum for sometime
(5) I will speak to Sean's mum.
(6) Missing at risk until recovered further.

T DASGUPTA

23/6/12 Reviewed with [illegible]

Nursing → seems better on clozapine c/o feeling more agitated after 5 pm & hypersalivation.

On review, Sean reports feeling better. Tablets are washing down voices feeling brighter, no paranoid attacks. Now I can read' - after exam is not a big bother. But finds it difficult to keep himself awake after morning dose.

Happy to have tablet for hypersalivation

Impression:- positive change on clozapine PZAN:- (1) Change 8am dose of clozapine to 1 pm.
(2) stop Risperidone
(3) Hyoscine HBr at night

(4) Clozapine serum level tomorrow

T. Dayanga

28/6/12 Reviewed Leon ward S/N Shona.
Improved in presentation.
Psychotic symptoms improved.
He reported feeling better.
continue with current plan

T.D ASGUPTA

3/7/12
Leon tells me he has been napping for hyperdrotic, which is more night. Drunk with pharmist Alia Hasbon who has agreed to ↑ Keppra to 700mg bd. Also Leon Nitrazepam has been ↓ to 7.5mg as he is mostly sleeping well.

[signature]
Dr

9/7/12
ATSP re Sue thought

Leon states he has had a sm chat yr 7/7. O/E there is no redness or evidence of any injuries. Obs within normal range and mentally appeared.

(P) (i) Check to try chat lounges
(ii) Bloods sent in. FBC.

[signature]
DAMA.

NAME LEON GLASTON	Continuation Sheet No.	Unit No.

12/7/12 UNC OC DASGUPTA

Nursing - Mental state much improved, settled on the ward. No physical health concerns. Mother has been visiting

℞ (i) Reduce nitrazepam to 5mg nocte
(ii) Allow unescorted leave to Lagan x 2 weekly for 2 hours.

DASGUPTA

16/7/12 Reviewed.
Leon c/o sore throat & loss of voice.
Vitals are normal.
sputum & urine sample however not shown any growth.
Advised on warm-gurgles & voice rest.

P. DASGUPTA

19/7/12 NR
Nursing → He is doing better mentally sometimes he is speaking normally sometimes in hoarse voice (? side role)
B.P → 110/70. temp 36°.
Tablets normal.
Not engaging well with any therapy.
He wants to go to his S. in community access bed.

Review → Bright & pleasant — well speaking
Has hoarse voice.
Enjoying psychology group.

PLAN: (1) Reduce Nitrazepam to 2.5mg nocte, to be stopped next week
(2) Increase clozapine by 25mg.
(3) Monitor hoarseness of voice — if doesn't get better or consistent — consider ENT referral.
(4) Community access bus unsecured

P. DASGUPTA

11/8/12

ATSP re lump in (R) testicle

I was asked to see him as he has had a painful lump arise over the last 24 hrs which is had in water. It measures 2cm x 2cm and is attached to the skin. No redness or broken skin. Physical obs within normal range. Pen is feeling physically well.

IMP Simple cyst.

(P) USS of testicles.

DOCA

23/8/12

UR DR DASGUPTA

Nurse - doing well on clozapine, but putting on weight.

Patient - Lipid ratio 7.8. Unless to find it difficult to get up in the morning

PRESCRIPTION SHEET (USE BLOCK LETTERS) RE-WRITTEN 10-4-12.

Sheet No. 10

	START DATE	DISCONTINUED Date	DISCONTINUED Signature	REGULAR MEDICINES	DOSE	METHOD OF ADMINISTRATION	TIME OF ADMINISTRATION 0800	1300	1800	2200	Other Times	PRESCRIBER'S SIGNATURE
A	29/9/2009			ARIPIPRAZOLE	30mg	ORAL	✓					
B	20/02/12			SERTRALINE	50mg	ORAL	✓					
C	~~12/3/12~~	~~23/3/12~~	~~P Dasgupta~~	~~CLOZAPINE SUSPENSION~~	~~25mg~~	~~ORAL~~	✓					
D	12/3/12	23/4/12	P Dasgupta	CLOZAPINE SUSPENSION	25mg	ORAL	✓					
E	~~23/4/12~~	~~28/5/12~~	~~P Dasgupta~~	~~CLOZAPINE SUSPENSION~~	~~25mg~~	~~ORAL~~			✓			
F	30/5/12			CLOZAPINE	250mg	oral	✓					
G	29/5/12			CLOZAPINE	275mg	oral			✓			
H	~~28/5/12~~	~~28/5/12~~	~~P Dasgupta~~	~~SERTRALINE~~	~~100mg~~	~~oral~~			✓			
I	28/5/12			SIMVASTATIN	40mg	oral				✓		
J												
K												
L												
M												
N												
O												
P												

Kevin 26/6/12

10

	START DATE	DISCONTINUED Date	DISCONTINUED Signature	AS REQUIRED MEDICINES	DOSE	METHOD OF ADMINISTRATION	INDICATION	MAXIMUM FREQUENCY	PRESCRIBER'S SIGNATURE
R	9/7/2009			HALOPERIDOL	5mg	ORAL	agitation	x3/24hrs	
S	10/7/2010			LORAZEPAM	2mg	ORAL	agitation	x2/24hrs	
T	9/7/2009			PROCYCLIDINE	5mg	ORAL	EPSE	x3/24hrs	
U	20/9/2011			Symptomatic relief as per	policy	except paracetamol			
W	24/10/2011			Paracetamol	1gm	ORAL	pain/fever	x4/24hrs	
X	16/1/2012			SENNA Tablets.	TWO	ORAL	constipation.	once 24hrs	
Y									
Z									

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

TICK IF PRESCRIBED ON THE FOLLOWING SHEET

LIST OF MEDICINES TO BE AVOIDED DUE TO PREVIOUS REACTION

MEDICINE	REFERRED DATE

High dose antipsychotics.

ONCE ONLY MEDICINES AND PREMEDICATION

DATE	MEDICINE	DOSE	METHOD OF ADMINISTRATION	TIME	PRESCRIBER'S SIGNATURE	GIVEN BY	GIVEN AT
28/5/12	CLOZAPINE Suspen	28mg	oral	1800	P Dasgupta	Sa Mishra RGN	
29/5/12	CLOZAPINE SUSP.	250mg	oral	0800	P Dasgupta	D.Z.	08:00am

DETAINED PATIENT
MHA (SCOT) 2003
Please consult with Treatment Plan (Form T2 or T3) before prescribing

NAME OF PATIENT [redacted] AGE [redacted] DATE OF BIRTH [redacted] UNIT No. [redacted] CONSULTANT DR DASGUPTA WARD RANKLAND

FHB(MR) 58

PASS MEDICATION RECORD Sheet No. 10 Ward F. ILKLAND Patient's Name MRY GALLOWAY Unit No. F5131078.

	STRENGTH	N Mitchell 16.4.12	N Cannon 23/4/12	C Morden 30.4.12	C Morden 30.4.12	C Morden 7.5.12	C Morden 14.5.12	CCCC 21/5/12	25/5/12	25/5/12	4/6/12	11/6/12	18.6.12	SIGNATURE OF NURSE IN CHARGE
A														
B														
C		x7 DOSES	X7 DOSES		x7 doses	x7 doses	x7 doses	x7 doses						
D		x7 DOSES												
E			X7 DOSES		x7 doses	x7 doses	x7 doses	x7 doses	x3 DOSES	x7 DOSES	x7 DOSE	x7	x7 Doses	NUMBER OF DOSES SUPPLIED
F									x3 DOSES	x7 DOSES	x7 DOSE	x7	x7 Doses	
G														
H														
I														
J														
K														
L														
M														
N														
O		Liquid	Liquid		Liquid	Liquid	Liquid	Liquid	Boxes	Boxes	Boxes	Boxes		
P		Please	Please		please	please	please	please	Please	Please	Please	Please		
		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	TICK AS REQUIRED MEDICATION ON EACH PASS
R														
S														
T														
U														
W														
X														
Y														
Z														
TIME LEAVING		14.00	14.00	14.00	14.00	14.00	14.00	14.00	14.00	14.00	12.00	12.00	14.00	TIME LEAVING
DATE LEAVING		20/4/12	27/4/12	30.4.12	4.5.12	11.5.12	18.5.12	25/5/12	29/5/12	1/6/12	8/6/12	15/6/12	22/6/12	DATE LEAVING
TIME RETURNING		14.00	14.00	14.00	14.00	14.00	14.00	14.00	14.00	14.00	12.00	12.00	14.00	TIME RETURNING
DATE RETURNING		27/4/12	4/5/12		11.5.12	18.5.12	25.5.12	1/6/12	1/6/12	8/6/12	15/6/12	22/6/12	29/6/12	DATE RETURNING
DATE AND DISPENSED BY														DATE AND DISPENSED B
CHECKED BY			E Morden											CHECKED BY
ISSUED BY			E Morden 26.4.12											ISSUED BY

PRESCRIPTION SHEET (USE BLOCK LETTERS) Lentik 16/3/12 Sheet No. 7

	START DATE	DISCONTINUED Date	DISCONTINUED Signature	REGULAR MEDICINES	DOSE	METHOD OF ADMINISTRATION	TIME OF ADMINISTRATION 0800	1300	1800	2200	Other Times	PRESCRIBER'S SIGNATURE
A	17/4/11			OMEPRAZOLE	20mg	ORAL	✓					
B	25/4/11			RISPERIDONE	1.5mg	ORAL				✓		
C	16/8/12	7/9/12		~~LOSEC RAPIDE CREAM~~	~~1mm~~	~~TOP~~	✓		✓			
D	25/6/12			CLOZAPINE	100mg	ORAL		✓				
E	3/7/12	13/9/12		~~HYOSCINE HYDROBROMIDE~~	~~300mg~~	~~ORAL~~		✓	✓	✓		
F	~~14/7/12~~	~~7/9/12~~	~~P. Dwyer~~	~~CLOZAPINE~~	~~225mg~~	~~ORAL~~			✓			
G	8/8/12			SERTRALINE	50mg	ORAL	✓					
H	16/8/12			LACTULOSE SACHET	1 Sachet	ORAL	✓		✓			
I	23/8/12			SIMVASTATIN	40mg	oral				✓		P. Dwyer
J	~~7/9/12~~	~~27/9/12~~	~~P. Dwyer~~	~~CLOZAPINE~~	~~250mg~~	~~oral~~			✓			P. Dwyer
K	~~7/9/12~~	~~10/9/12~~		~~CHOLASEN~~	~~1 sachet~~	~~TOP~~	✓		✓			
L	10/9/12			CETRABEN	1 BOTT	TOP	✓		✓			
M	19/9/12	27/9/12	P. Dwyer	HYOSCINE HYDROBROMIDE	300mg	ORAL		✓		✓		
N	27/9/12			HYOSCINE HYDROBROMIDE	300mg	oral		✓	✓	✓		P. Dwyer
O	28/9/12			CLOZAPINE	275mg	oral				✓		P. Dwyer
P	2-7/9/12			PARACETAMOL	1gm	oral			✓			P. Dwyer

	START DATE	DISCONTINUED Date	DISCONTINUED Signature	AS REQUIRED MEDICINES	DOSE	METHOD OF ADMINISTRATION	INDICATION	MAXIMUM FREQUENCY	PRESCRIBER'S SIGNATURE
R	14/10/11			E45 CREAM	2MMS	TOPICAL	DRY SKIN	PRN	
S	19/10/11			SOFT PARAFFIN (YELLOW)	1mm	TOPICAL	ANY SKIN	PRN	
T	16/11/11			HALOPERIDOL	5mg	ORAL	AGITATION	20mg / 24 hrs	
U	16/8/11			SYMPTOMATIC RELIEF (ELIXIR)		MAALOX PARACETAMOL			
W	22/6/12	27/9/12	P. Dwyer	PARACETAMOL	1g	ORAL	PAIN	4g / 24hrs	
X	3/9/12			MAALOX	10-20ml	ORAL	DYSPEPSIA	x2 / 24hrs	
Y	27/9/12			PARACETAMOL	1gm	oral	PRN	3g / 24 hours	P. Dwyer
Z									

	START DATE	DISCONTINUED Date	DISCONTINUED Signature	DEPOT INJECTIONS	DOSE	FREQUENCY	PRESCRIBER'S SIGNATURE
1					2.5ml	6/52	
2							
3							
4							

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

ONCE ONLY MEDICINES AND PREMEDICATION

DATE	MEDICINE	DOSE	METHOD OF ADMINISTRATION	TIME	PRESCRIBER'S SIGNATURE	GIVEN BY	GIVEN AT
27/9/12	CLOZAPINE	250mg	oral	2200	P. Dwyer	Mary Greene	22.00

NAME OF PATIENT | AGE | DATE OF BIRTH | UNIT No. | CONSULTANT | WARD DUNINO

FHB(MR) 58

PASS MEDICATION RECORD Sheet No. 7 Ward O. [illegible] Patient's Name L [illegible] GRATTON Unit No. 1703751191

	STRENGTH	16/8/12 [illegible]	22.8.12 [illegible]	J Coote 29/8/12	J Coote 05/09/12	[illegible] 5.9.12	J Coote 12/9/12	A Coote 19/9/12	Mary [illegible] 27/9/12	[illegible] 28.9.12	A. Mowatt 4/10/12	J Eccles 9.10.12	D [illegible] 18/10/12	SIGNATURE OF NURSE IN CHARGE
A														
B														
C	TUBE				x2.	x2								
D	10 mg	x7	x7	x7	x7	x7	x7	x7	x7	x7	x7	x7	x7	NUMBER OF DOSES SUPPLIED
E														
F	225 mg	x7	x7	x7	x7									
G														
H														
I														
J	750mgs					x7	x7	x7	x7					
K														
L														
M														
N														
O	75 mg									x7	x7	x7	x7	
P														

	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	TICK AS REQUIRED MEDICATION ON EACH PASS
R													
S													
T													
U													
W													
X													
Y													
Z													
TIME LEAVING	14.00	14.00	1400	1400	14.00	1400	14.00	14.00	14.00	14.00	14.00	1400	TIME LEAVING
DATE LEAVING	17.8.12	24.8.12	31/8/12	07/09/12	7.9.12	14/09/12	21/9/12	28/9/12	28.9.12	05/10/12	12.10.12	19/10/12	DATE LEAVING
TIME RETURNING	14.00	14.00	1400	1400	14.00	1400	14.00	14.00	14.00	14.00	14.00	1400	TIME RETURNING
DATE RETURNING	24.8.12	31.8.12	7/9/12	14/09/12	14.9.12	21/09/12	28/9/12	5/10/12	5.10.12	12/10/12	19.10.12	26/10/12	DATE RETURNING
DATE AND DISPENSED BY													DATE AND DISPENSED BY
CHECKED BY	[illegible] (BANDS)	[illegible]	[illegible]		[illegible]	[illegible]	[illegible] Davidson		[illegible]	[illegible] (BANDS)	[illegible] (BANDS)		CHECKED BY
ISSUED BY													ISSUED BY

PRESCRIPTION SHEET (USE BLOCK LETTERS)

Sheet No.

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

	START DATE	DISCONTINUED Date	DISCONTINUED Signature	AS REQUIRED MEDICINES	DOSE	METHOD OF ADMINISTRATION	INDICATION	MAXIMUM FREQUENCY	PRESCRIBER'S SIGNATURE
R									
S									
T									
U									
W									
X									
Y									
Z									

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

TICK IF PRESCRIBED ON THE FOLLOWING SHEET

LIST OF MEDICINES TO BE AVOIDED DUE TO PREVIOUS REACTION

	MEDICINE	REFERRED DATE

ONCE ONLY MEDICINES AND PREMEDICATION

DATE	MEDICINE	DOSE	METHOD OF ADMINISTRATION	TIME	PRESCRIBER'S SIGNATURE	GIVEN BY	GIVEN AT
29/8/12	CLOZAPINE	100MG	ORAL	2200			

NAME OF PATIENT LEON GRATTON

AGE 27 | DATE OF BIRTH 14/7/1975 | UNIT No. 1703751191

CONSULTANT

WARD DUNNO

FHB(MR) 58

PASS MEDICATION RECORD Sheet No. Ward DUNINO Patient's Name LEON GRATTON Unit No. 1703751191

	STRENGTH													SIGNATURE OF NURSE IN CHARGE
A														
B														
C														
D														
E														
F														
G														
H														
I														
J														
K														
L														
M														
N														
O														
P														

NUMBER OF DOSES SUPPLIED

	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	**TICK AS REQUIRED MEDICATION ON EACH PASS**
R													
S													
T													
U													
W													
X													
Y													
Z													
TIME LEAVING													TIME LEAVING
DATE LEAVING													DATE LEAVING
TIME RETURNING													TIME RETURNING
DATE RETURNING													DATE RETURNING
DATE AND DISPENSED BY													DATE AND DISPENSED BY
CHECKED BY													CHECKED BY
ISSUED BY													ISSUED BY

PRESCRIPTION SHEET (USE BLOCK LETTERS) Reddle 21/12 Sheet No. 1

	START DATE	DISCONTINUED Date	DISCONTINUED Signature	REGULAR MEDICINES	DOSE	METHOD OF ADMINISTRATION	TIME OF ADMINISTRATION 0800	1300	1800	2200	Other Times	PRESCRIBER'S SIGNATURE
A	17/9/11			OMEPRAZOLE	20mg	ORAL	✓					
B	23/9/11			PIZOTIFEN	1.5mg	ORAL				✓		
C	8/3/12	8/8/12		SERTRALINE	50mg	ORAL	✓					
D	15/5/12	16/8/12		ADULT SENNA CREAM	1 APP	TOP	✓			✓		
E	21/6/12	19/7/12	P. Dunlop	CLOZAPINE	200mg	ORAL				✓		
F	25/6/12			CLOZAPINE	100mg	ORAL		✓				
G	3/7/12	12/7/12	P. Dunlop	NITRAZEPAM	7.5mg	ORAL				✓		
H	3/7/12			ICWELLS HYOSCINE HYDROBROMIDE	300mcg	ORAL		✓		✓		
I	5/7/12	6/8/12		LAXIDO SACHET	1 Sachet	ORAL	✓			✓		
J	12/7/12	12/7/12	P. Dunlop	NITRAZEPAM	5mg	ORAL				✓		P Dunlop
K	12/7/12											
L	19/7/12	6/8/12	P. Dunlop	NITRAZEPAM	2.5mg	ORAL				✓		P Dunlop
M	19/7/12			CLOZAPINE	225mg	ORAL				✓		P Dunlop
N	6/8/12	16/8/12		LAXIDO SACHET	1 Sachet	ORAL	✓					
O	8/8/12			SERTRALINE	50mg	ORAL	✓					
P	16/8/12	16/8/12		LAXIDO SACHET	1 Sachet	ORAL	✓					

	START DATE	DISCONTINUED Date	DISCONTINUED Signature	AS REQUIRED MEDICINES	DOSE	METHOD OF ADMINISTRATION	INDICATION	MAXIMUM FREQUENCY	PRESCRIBER'S SIGNATURE
R	14/10/11			~~HYDROCORTISONE~~ E45 CREAM	2APP	TOP	DRY SKIN	PRN	
S	19/10/11			SOFT PARAFIN (YELLOW)	1APP	TOP	DRY SKIN	PRN	
T	16/11/11			HALOPERIDOL	5mg	ORAL	AGITATION	10mg/24hrs	
U	20/1/12	16/8/12		MANNA	20mg	ORAL	CONSTIPATION	40g/24hrs	
W	22/1/12	16/8/12		SYMPTOMATIC RELIEF (RELIEF PARACETAMOL)	1APP	TOPICAL	SORE GUMS	PRN	
X	7/2/12	16/8/12		LONTEZA (ADULT)	1APP	TOPICAL	SORE GUMS	4g/24hrs	
Y	5/9/12	16/8/12		IBUPROFEN	200mg	ORAL	PAIN	1.2g/24hrs	
Z	22/6/12			PARACETAMOL	1g	ORAL	PAIN	4g/24hrs	

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

TICK IF PRESCRIBED ON THE FOLLOWING SHEET ✓

LIST OF MEDICINES TO BE AVOIDED DUE TO PREVIOUS REACTION

MEDICINE	REFERRED DATE
NKDA	

ONCE ONLY MEDICINES AND PREMEDICATION

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

NAME OF PATIENT [illegible] GATTON | AGE 36 | DATE OF BIRTH 7/3/75 | UNIT No. 1037511 9 | CONSULTANT [illegible] | WARD FHB(MR) 58 [illegible]

PASS MEDICATION RECORD Sheet No. 5 Ward DUNJO Patient's Name LEON GRATTON Unit No. 170375 1191

	STRENGTH	12/7/12	20/7/12	19/7/12	19/7/12	25/7	2/8/12	8/8/12	15/8/12					SIGNATURE OF NURSE IN CHARGE
		12.7.12	20.7.12	19/7/12	19/7/12		Mary Gorrie	A Cronin	A Cronin					
A														
B														
C														
D														
E	200mg	x7	x7			X7	x7	x7	x7					NUMBER OF DOSES SUPPLIED
F	100mg	x7	x7	x7		X7	x7	x7	x7					
G														
H														
I														
J														
K														
L														
M	225mg			x7	x1 25mg	X7	x7	x7	x7					
N														
O														
P														

	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	TICK AS REQUIRED MEDICATION ON EACH PASS
R													
S													
T													
U													
W													
X													
Y													
Z													
TIME LEAVING	14.00	14.00	14.00	2200hrs	1600	14.00	14.00	14.00					TIME LEAVING
DATE LEAVING	13.7.12	20.7.12	20.7.12	19/7/12	27/7/12	3/8/12	10/8/12	17/8/12					DATE LEAVING
TIME RETURNING	14.00	14.00	14.00	2200hrs	1600	14.00	14.00	14.00					TIME RETURNING
DATE RETURNING	20.7.12	27.7.12	27.7.12	19/7/12	3/8/12	10/8/12	17/8/12	24/8/12					DATE RETURNING
DATE AND DISPENSED BY													DATE AND DISPENSED BY
CHECKED BY	Mary Gorrie		A Cronin	A Cronin									CHECKED BY
ISSUED BY													ISSUED BY

PRESCRIPTION SHEET (USE BLOCK LETTERS) Kendle 14106/1C. Sheet No. 1

	START DATE	DISCONTINUED Date	DISCONTINUED Signature	REGULAR MEDICINES	DOSE	METHOD OF ADMINISTRATION	TIME OF ADMINISTRATION 0800	1300	1800	2200	Other Times	PRESCRIBER'S SIGNATURE
A	8/9/11	3/7/12		AMLODIPINE	10mg	ORAL				✓		
B	17/9/11			OMEPRAZOLE	20mg	ORAL	✓					
C	25/11/11			PIZOTIFEN	1.5mg	ORAL				✓		
D	8/3/12			SEROKLINE	50mg	ORAL	✓					
E	15/5/12			ROSE FRASER CREAM	1APP	TOPICAL				✓		
F	15/6/12	18/6/12	P.Dempah	RISPERIDONE	1mg	ORAL	✓			✓		
G	8/6/12	21/6/12		CLOZAPINE	4 PRESCRIBED	ORAL	✓			✓		
H	8/6/12	25/6/12	P.Dempah	RISPERIDONE	1mg	ORAL				✓		P.Dempah
I	21/6/12	25/6/12	P.Dempah	CLOZAPINE	100mg	ORAL	✓					
J	21/6/12			CLOZAPINE	200mg	ORAL				✓		
K	25/6/12			CLOZAPINE	100mg	ORAL						P.Dempah
L	25/6/12	3/7/12		KWELLS HYPOACTIVE HYDROCARBON	300mg	ORAL				✓		P.Dempah
M	3/7/12	3/7/12		NITRAZEPAM	5mg	ORAL				✓		
N	3/7/12	3/7/12		KWELL HYGIENE HYDROCARBON	300mg	ORAL				✓		
O	3/7/12			NITRAZEPAM	7.5mg	ORAL				✓		
P	3/7/12			KWELL HYGIENE HYDROCARBON	3CAPS	ORAL				✓		

	START DATE	DISCONTINUED Date	DISCONTINUED Signature	AS REQUIRED MEDICINES	DOSE	METHOD OF ADMINISTRATION	INDICATION	MAXIMUM FREQUENCY	PRESCRIBER'S SIGNATURE
R	14/10/11			E45 CREAM	2APPS	TOP	DRY SKIN	PRN	
S	19/10/11			10% PARAFFIN (YELLOW)	1APP	TOP	DRY SKIN	PRN	
T	16/11/11			HALOPERIDOL	5mg	ORAL	AGITATION	20mg/24hrs	
U	20/1/12			MAALOX	20ml	ORAL	DYSPEPSIA	x3/24hrs	
W	27/1/12			SYMPTOMATIC RELIEF (EXCEPT PARACETAMOL + MAALOX)					
X	7/2/12			GONZILA (ADULT)	1APP	TOP/ORAL	SORE GUMS	x3/24hrs	
Y	5/3/12			IBUPROFEN	200mg	ORAL	PAIN	x3/24hrs	
Z	22/4/12			PARACETAMOL	1g	ORAL	PAIN	4g/24hrs	

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

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

ONCE ONLY MEDICINES AND PREMEDICATION

DATE	MEDICINE	DOSE	METHOD OF ADMINISTRATION	TIME	PRESCRIBER'S SIGNATURE	GIVEN BY	GIVEN AT
14/6/12	RISPERIDONE	2mg	ORAL	2200			2205

NIKOA.

NAME OF PATIENT [redacted] | AGE 36 | DATE OF BIRTH 17/3/75 | UNIT No. 17035119 | CONSULTANT DK DASGUPTA | WARD FHB(MR) 58 JUNIPER

PASS MEDICATION RECORD Sheet No. 5 Ward Nimmo Patient's Name Leon Gretton Unit No. 703751191

	STRENGTH	21/6/12	21/6	4/7/12										SIGNATURE OF NURSE IN CHARGE
A														
B														
C														
D														
E														NUMBER OF DOSES SUPPLIED
F														
G														
H														
I	100mg	x7	XVII											
J	200mg	x7	x7	x7										
K	100mg		x7	x7										
L														
M														
N														
O														
P														

	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	TICK AS REQUIRED MEDICATION ON EACH PASS
R													
S													
T													
U													
W													
X													
Y													
Z													
TIME LEAVING	1400	14.00	14-00										TIME LEAVING
DATE LEAVING	22/6/12	09/06/12	6/7/12										DATE LEAVING
TIME RETURNING	1400	14.00	14-00										TIME RETURNING
DATE RETURNING	29/6/12	6/07/12	13.7.12										DATE RETURNING
DATE AND DISPENSED BY													DATE AND DISPENSED BY
CHECKED BY			A Courtie										CHECKED BY
ISSUED BY													ISSUED BY

PRESCRIPTION SHEET (USE BLOCK LETTERS) Renew 30/4/12 4mg Sheet No. 4

	START DATE	DISCONTINUED Date	DISCONTINUED Signature	REGULAR MEDICINES	DOSE	METHOD OF ADMINISTRATION	TIME OF ADMINISTRATION 0800	1300	1800	2200	Other Times	PRESCRIBER'S SIGNATURE
A	8/9/11			NITRAZEPAM	10mg	ORAL				✓		
B	17/9/11			OMEPRAZOLE	20mg	ORAL	✓					
C	25/11/11			RIZATRIPTAN	10mg	ORAL				✓		
D	8/3/12			SERTRALINE	50mg	ORAL	✓					
E	26/4/12	3/5/12		METHOTREXATE 4/4	5mg	ORAL	✓			✓		
F	26/4/12	3/5/12		RISPERIDONE	1mg	ORAL	✓					
G	26/4/12	4/5/12		RISPERIDONE	2mg	ORAL				✓		
H	3/5/12	4/5/12		RISPERIDONE	2mg	ORAL	✓					
I	3/5/12	10/5/12	P Dunlop	RISPERIDONE	2mg	ORAL	✓			✓		
J	10/5/12	21/5/12		RISPERIDONE	2mg	oral	✓					P Dunlop
K	10/5/12	7/6/12	P Dunlop	RISPERIDONE	3mg	oral				✓		P. Dunlop
L	15/5/12			ROSE WATER CREAM	1 app	TOPICAL	✓			✓		
M	22/5/12	24/5/12	P Dunlop	RISPERIDONE	2mg	ORAL		✓				
N	24/5/12	7/6/12	P Dunlop	RISPERIDONE	3mg	oral		✓				P Dunlop
O	7/6/12	14/6/12		RISPERIDONE	2mg	oral		✓		✓		P Dunlop
P	8/6/12			CLOZAPINE	as per schedule	oral	✓			✓		P Dunlop

	START DATE	DISCONTINUED Date	DISCONTINUED Signature	AS REQUIRED MEDICINES	DOSE	METHOD OF ADMINISTRATION	INDICATION	MAXIMUM FREQUENCY	PRESCRIBER'S SIGNATURE
R	14/10/11			E45	2 APP	TOP	DRY SKIN/ITCHING	PRN	
S	19/10/11			SOFT PARAFFIN (YELLOW)	1 APP	TOP	DRY SKIN	PRN	
T	16/11/11			HALOPERIDOL	5mg	ORAL	AGITATION	2 mg/24hr	
U	28/1/12			MAALOX	20ml	ORAL	DYSPEPSIA	x 3/24hr	
W	27/1/12			SYMPTOMATIC RELIEF: (EXCEPT	PARACETAMOL + MAALOX) AS PER PROTOCOL				
X	7/2/12			BONTELA (APPLY)	1 APP	TOP	SORE LIPS	x 3/24hr	
Y	5/3/12			IBUPROFEN	200mg	ORAL	ANALGESIA	x 3/24hr	
Z	22/6/12			PARACETAMOL	1g	ORAL	PAIN	4g/24hr	

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

Renew 14/6/12

TICK IF PRESCRIBED ON THE FOLLOWING SHEET ✓

LIST OF MEDICINES TO BE AVOIDED DUE TO PREVIOUS REACTION

MEDICINE	REFERRED DATE

ONCE ONLY MEDICINES AND PREMEDICATION

DATE	MEDICINE	DOSE	METHOD OF ADMINISTRATION	TIME	PRESCRIBER'S SIGNATURE	GIVEN BY	GIVEN AT
			OMEPRAZOLE				
24/5/12	OMEPRAZOLE	20mg	ORAL	1130			1145
4/5/12	SERTRALINE	50mg	ORAL	1130			1145
4/5/12	RISPERIDONE	1mg	ORAL	1130			1140

NKDA.

NAME OF PATIENT [redacted] | AGE 76 | DATE OF BIRTH 17/1/35 | UNIT No. 170276191 | CONSULTANT DR MASLANKA | WARD FHB(MR) 58 QUINCE

PASS MEDICATION RECORD Sheet No. 4 Ward Domino Patient's Name Leon Gutton Unit No. 17037511 91

	STRENGTH													SIGNATURE OF NURSE IN CHARGE
A		7.6.12												
B														
C														
D														
E														
F														
G														
H														
I														
J														
K														
L														
M														
N														
O														
P														

NUMBER OF DOSES SUPPLIED

	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
R													
S													
T													
U													
W													
X													
Y													
Z													

TICK AS REQUIRED MEDICATION ON EACH PASS

TIME LEAVING	14⁰⁰	11.00											TIME LEAVING
DATE LEAVING	8.6.12	15.6.12											DATE LEAVING
TIME RETURNING	14⁰⁰	11.00											TIME RETURNING
DATE RETURNING	15.6.12	21.6.12											DATE RETURNING
DATE AND DISPENSED BY													DATE AND DISPENSED BY
CHECKED BY	Mary Marie Gutton												CHECKED BY
ISSUED BY													ISSUED BY

PRESCRIPTION SHEET (USE BLOCK LETTERS) Remove 11/12. 1 of 4 Sheet No. 2

	START DATE	DISCONTINUED Date	DISCONTINUED Signature	REGULAR MEDICINES	DOSE	METHOD OF ADMINISTRATION	TIME OF ADMINISTRATION 0800	1300	1800	2200	Other Times	PRESCRIBER'S SIGNATURE
A	8/9/11			NITRAZEPAM Removed	10mg	ORAL				✓		
B	8/9/11	23/2/12	P Danyan	CITALOPRAM	20mg	ORAL	✓					
C	12/9/11			OMEPRAZOLE	20mg	ORAL	✓					
D	25/11/11			PIZOTIFEN	1.5mg	ORAL				✓		
E	2/12/11	19/4/12	P Danyan	PARACETAMOL	1g	ORAL	✓	✓	✓	✓		
F	26/1/12	16/2/12	P Danyan	TRIFLUOPERAZINE	10mg	ORAL	✓			✓		
G	16/2/12	23/2/12	P Danyan	TRIFLUOPERAZINE	10mg	oral	✓					P. Danyan
H	16/2/12	23/2/12	P Danyan	TRIFLUOPERAZINE	15mg	oral				✓		P. Danyan
I	23/2/12	19/4/12	P. Danyan	TRIFLUOPERAZINE liq.	15mg/5ml	oral	✓			✓		P Danyan
J	23/2/12	27/2/12	Danyan	CITALOPRAM	1Pmg	oral	✓					P Danyan
K	8/3/12			SERTRALINE	50mg	oral	✓					P. Danyan
L	19/4/12	26/4/12	P. Danyan	TRIFLUPERAZINE liq	10ml	oral	✓			✓		P. Danyan
M	19/4/12	23/4/12	P Danyan	RISPERIDONE	1mg	oral				✓		P. Danyan
N	23/4/12	26/4/12	P Danyan	RISPERIDONE	1mg	oral	✓			✓		P. Danyan
O	26/4/12			TRIFLUPERAZINE liq	5ml	oral	✓			✓		P. Danyan
P												

	START DATE	DISCONTINUED Date	DISCONTINUED Signature	AS REQUIRED MEDICINES	DOSE	METHOD OF ADMINISTRATION	INDICATION	MAXIMUM FREQUENCY	PRESCRIBER'S SIGNATURE
R	14/10/11			E45	2AM	TOPICAL	DRY SKIN	PRN	
S	10/10/11			SOFT PARAFFIN	2AM	TOPICAL	DRY SKIN	PRN	
T	16/1/11	23/2/12		DICLOFENAC SODIUM	50mg	RECTAL	~~PAIN~~	8P	
U	16/1/11			HALOPERIDOL	5mg	ORAL	AGITATION	20mg/24hrs	
W	28/1/12			MAALOX	20ml	ORAL	DYSPEPSIA	PRN x 3/24hrs	
X	27/1/12			SYMPTOMATIC RELIEF (EXCEPT PARACETAMOL AND MAALOX)				AS PER PROTOCOL	
Y	27/2/12			BONJELA (ADULT).	1APP	TOPICAL	SORE GUMS	~~PRN~~ x 3/24hrs	
Z	5/3/12			IBUPROFEN	200mg	ORAL	ANALGESIA	600mg/24hrs	

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

TICK IF PRESCRIBED ON THE FOLLOWING SHEET

LIST OF MEDICINES TO BE AVOIDED DUE TO PREVIOUS REACTION

MEDICINE	REFERRED DATE
	HDH
NKDA.	

ONCE ONLY MEDICINES AND PREMEDICATION

DATE	MEDICINE	DOSE	METHOD OF ADMINISTRATION	TIME	PRESCRIBER'S SIGNATURE	GIVEN BY	GIVEN AT
13/2/12	CIPALORAM	20mg	ORAL	1145		A Cassidy	11.45
13/2/12	METRAZOLE	20mg	ORAL	1145		A Cassidy	11.65
13/2/12	PIZOTIFEN	1.5mg	ORAL	1145		Not given	
13/2/12	TRIFLUOPERAZINE	10mg	ORAL	1145		A Cassidy	11.65

NAME OF PATIENT [redacted] | AGE 71 | DATE OF BIRTH 17/2/75 | UNIT No. 1703751191 | CONSULTANT Dr Dasgupta | WARD OLIVER

FHB(MR) 58

PASS MEDICATION RECORD Sheet No. 2 Ward 1 NINO Patient's Name JON GRATTON Unit No. 1703751191

	STRENGTH												SIGNATURE OF NURSE IN CHARGE
A													
B													
C													
D													
E													NUMBER OF DOSES SUPPLIED
F													
G													
H													
I													
J													
K													
L													
M													
N													
O													
P													

	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
R													TICK AS REQUIRED MEDICATION ON EACH PASS
S													
T													
U													
W													
X													
Y													
Z													
TIME LEAVING													TIME LEAVING
DATE LEAVING													DATE LEAVING
TIME RETURNING													TIME RETURNING
DATE RETURNING													DATE RETURNING
DATE AND DISPENSED BY													DATE AND DISPENSED BY
CHECKED BY													CHECKED BY
ISSUED BY													ISSUED BY

PRESCRIPTION SHEET (USE BLOCK LETTERS)

Sheet No. 3

	START DATE	DISCONTINUED Date	DISCONTINUED Signature	REGULAR MEDICINES	DOSE	METHOD OF ADMINISTRATION	TIME OF ADMINISTRATION 0800	1300	1800	2200	Other Times	PRESCRIBER'S SIGNATURE
A	26/4/12			RISPERIDONE	1mg	oral	✓					P. Donyapi
B	26/4/12			RISPERIDONE	2mg	oral				✓		P. Donyapi
C												
D												
E												
F												
G												
H												
I												
J												
K												
L												
M												
N												
O												
P												

	START DATE	DISCONTINUED Date	DISCONTINUED Signature	AS REQUIRED MEDICINES	DOSE	METHOD OF ADMINISTRATION	INDICATION	MAXIMUM FREQUENCY	PRESCRIBER'S SIGNATURE
R	2/4/12			BOSS FRASER CREAM	1 APP	TOP	DRY SKIN	2s REQUIRED	
S	22/4/12			PARACETAMOL	1g	oral	PAIN	4-6°	
T									
U									
W									
X									
Y									
Z									

	START DATE	DISCONTINUED Date	DISCONTINUED Signature	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
1										
2										
3								✓		
4										

ONCE ONLY MEDICINES AND PREMEDICATION

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

NAME OF PATIENT | AGE | DATE OF BIRTH | UNIT No. | CONSULTANT | WARD FHB(MR)SDJWN 0

PASS MEDICATION RECORD Sheet No. Ward Patient's Name Unit No.

	STRENGTH												SIGNATURE OF NURSE IN CHARGE
A													
B													
C													
D													
E													
F													
G													
H													
I													
J													
K													
L													
M													
N													
O													
P													

NUMBER OF DOSES SUPPLIED

	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	
R													
S													
T													
U													
W													
X													
Y													
Z													
TIME LEAVING													TIME LEAVING
DATE LEAVING													DATE LEAVING
TIME RETURNING													TIME RETURNING
DATE RETURNING													DATE RETURNING
DATE AND DISPENSED BY													DATE AND DISPENSED BY
CHECKED BY													CHECKED BY
ISSUED BY													ISSUED BY

TICK AS REQUIRED MEDICATION ON EACH PASS

PRESCRIPTION SHEET (USE BLOCK LETTERS) Kenmuir 14/12/11 (FROM DR. CANAVAN) Sheet No. 1 (STRATHCLYDE)

	START DATE	DISCONTINUED Date	DISCONTINUED Signature	REGULAR MEDICINES	DOSE	METHOD OF ADMINISTRATION	TIME OF ADMINISTRATION 0800	1300	1800	2200	Other Times	PRESCRIBER'S SIGNATURE
A	8/9/11			NITRAZEPAM	10MG	ORAL				✓		
B	8/9/11			CITALOPRAM	20MG	ORAL	✓					
C	12/9/11			OMEPRAZOLE	20MG	ORAL	✓					
D	14/11/11	26/1/12	P.Dunlop	~~TRIFLUOPERAZINE~~	~~15MG~~	~~ORAL~~				~~✓~~		
E	29/11/11			PIZOTIFEN	1.5MG	ORAL				✓		
F	2/12/11			PARACETAMOL	1G	ORAL	✓	✓	✓	✓		
G	~~22.1.2012~~	~~26-1-2012~~	~~SE~~	~~CERUMOL EAR drops~~	~~5ml~~	~~Both ears~~	✓			✓		
H	26/1/12			TRIFLUOPERAZINE	10mg	oral	✓			✓		P.Dunlop
I												
J												
K												
L												
M												
N												
O												
P												

Kmuir 7/1/12.

	START DATE	DISCONTINUED Date	DISCONTINUED Signature	AS REQUIRED MEDICINES	DOSE	METHOD OF ADMINISTRATION	INDICATION	MAXIMUM FREQUENCY	PRESCRIBER'S SIGNATURE
R	8/9/11	22.12.2012	CS	~~SYMPTOMATIC RELIEF~~	~~AS~~	~~PER PROTOCOL~~	~~(EXCEPT PARACETAMOL~~		
S	14/10/11			E45	½	TOPICAL	DRY SKIN	PRN	
T	14/10/11			SOFT PARAFFIN	½	TOPICAL	DRY SKIN	PRN	
U	22/11/11	12/12/11		~~DICLOFENAC SODIUM~~	~~50MG~~	~~ORAL~~	~~PAIN~~	ONCE DAILY	
W	12/12/11			DICLOFENAC SODIUM	50MG	ORAL	PAIN	BD	
X	16/1/2012			HALOPERIDOL	5mg	ORAL	agitation	x4 / Max 20mg/day	
Y	27.1.2012			MAALOX	20ml	ORAL	Dyspepsia	x3 / Max 6ml/24h	
Z	27.1.2012			symptomatic relief except for Maalox					

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

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

ONCE ONLY MEDICINES AND PREMEDICATION

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

NAME OF PATIENT [illegible] CRATTON | AGE 72 | DATE OF BIRTH 17/2/39 | UNIT No. 170375 1191 | CONSULTANT ~~CAVANAGH~~ Dasgupta | WARD STRATHCLYDE HOSP. QUINN

PASS MEDICATION RECORD Sheet No. 1 Ward Patient's Name Unit No.

	STRENGTH												SIGNATURE OF NURSE IN CHARGE
A													
B													
C													
D													
E													
F													
G													
H													
I													
J													
K													
L													
M													
N													
O													
P													

NUMBER OF DOSES SUPPLIED

	✓		✓		✓		✓		✓		✓		✓		✓		✓		✓		✓		TICK AS REQUIRED MEDICATION ON EACH PASS
R																							
S																							
T																							
U																							
W																							
X																							
Y																							
Z																							
TIME LEAVING																							TIME LEAVING
DATE LEAVING																							DATE LEAVING
TIME RETURNING																							TIME RETURNING
DATE RETURNING																							DATE RETURNING
DATE AND DISPENSED BY																							DATE AND DISPENSED BY
CHECKED BY																							CHECKED BY
ISSUED BY																							ISSUED BY

NB – A NEW RECORDING SHEET MUST BE TAKEN EACH TIME A PRESCRIPTION SHEET IS CHANGED
PRESCRIPTION SHEET No. 6

KEY
Ⓐ DRUG REFUSED
Ⓐ̸ PATIENT ABSENT

MEDICINE RECORDING SHEET

Date	REGULAR PRESCRIPTIONS 8.00	Intls	13.00	Intls	18.00	Intls	22.00	Intls	OTHER TIMES Code	Time	Intls	Code	Time	Intls	Code	Time	Intls	DEPOT INJECTION Code	Intls	AS REQUIRED Code	Time	Intls	Code	Time	Intls	COMMENTS ON DISCREPANCIES
16/8/12	7 Ⓓ N O	[illegible]			C E F 1+	[illegible]														W	11.20	[illegible]				D [illegible]

NAME: Leon Gratton UNIT No: 1703751191 WARD: Dunend

NB – A NEW RECORDING SHEET MUST BE TAKEN EACH TIME A PRESCRIPTION SHEET IS CHANGED

PRESCRIPTION SHEET No. 6

KEY
D DRUG REFUSED
Ø PATIENT ABSENT

MEDICINE RECORDING SHEET

REGULAR PRESCRIPTIONS

Date	8.00	Initls	13.00	Initls	18.00	Initls	22.00	Initls	OTHER TIMES Code	Time	Initls	Code	Time	Initls	Code	Time	Initls
2/8/12	A C D I	gm SM	F H	MC			B D H I L M	MC									
3/8/12	A C D I	SM MC	F H	MC			B D H I L M	Ø									
4/8/12	A C D I	AW MC	F H	MC			B D H I L M	Ø									
5/8/12	A C D I	gm AW	F H	gm AW			B D H I L M	Ø									
6/8/12	A C D I	SM MC	F H	MC SM			B D H M	Ø									
7/8/12	A C D N	AC LWT	F H	MC LWT			B D H M	AC									
8/8/12	A C D N	AW MC	F H	gm MC			B D H M	AC									
9/8/12	A D N O	AC MC	F H	MC AC			B H D M	AC									
10/8/12	A D N O	D AC	F H	gm SM			B H D M	AC									
11/8/12	A D N O	D SM	F H	gm			B D H M	Ø	Ø	0555	MC						
12/8/12	A D N O	AW MC	F H	MC AW			B D H M	Ø									
13/8/12	A D N O	gm MC	F H	gm MC			B D H M	Ø									
14/8/12	A D N O	LS MC	F H	LS MC			B D H M	Ø									
15/8/12	A D N O	LS D	F H	MC			B H D M	AC									

DEPOT INJECTION Code	Initls

AS REQUIRED

Code	Time	Initls	Code	Time	Initls
U	23.15	MC			
Z / T	9.00 / 15.00	AW MC			
T					
‡	12.00	gm			
‡	1410	MC			
00.05 / 1805	Z / Z	Ø SM MC			
Z	1645	gm			
U / ‡ / Z	1.30 / 1805 / 1810	AC MC gm	Z	23.00	AC
Z / Z	16.40 / 2000	gm gm			
Z / T	5.45 / 11.00	AC gm			
Z / ‡ / ‡	1250 / 1755 / 1800	AC MC MC			

COMMENTS ON DISCREPANCIES

- D – Self admin
- D – Self admin
- D – Self admin
- I – refused.
- T – Refused
- D – Self Admin
- D – self admin
- Z – headache
- I – refused
- D – Self admin
- ‡ – headache.
- D – Self admin
- Z – headache
- D – self admin
- D – self admin
- D – Self admin
- ‡ – headache.
- Self ADMIN D
- ‡ headache.
- D – self admin
- Z – headache
- D Refused
- ‡ – headache
- Z – headache
- D self admin
- D self admin
- D Self admin

NAME: LEON GRATTON UNIT No: 1703751191 WARD: DUNNS WARD STRATHMORE

NB – A NEW RECORDING SHEET MUST BE TAKEN EACH TIME A PRESCRIPTION SHEET IS CHANGED

PRESCRIPTION SHEET No. 6

KEY
(A) DRUG REFUSED
(A) PATIENT ABSENT

MEDICINE RECORDING SHEET

REGULAR PRESCRIPTIONS

Date	8.00	Intls	13.00	Intls	18.00	Intls	22.00	Intls
19/7/12	A C D I	QC MC	F H L	MC QC			B D H I L M	QI
20/7/12	A C D I	QC MC	F H	MC			B D H I L M	QI
21/7/12	A C D I	SM QC	F H L	MC QC			B D H I L M	QI
22/7/12	A C D I	QC MC	F H	MC QC			B D H I L M	YS
23/7/12	D I	QC	F H	QC			B D H I L M	YS
24/7/12	A C D I	QC MC	F H L	MC QC			B D H I L M	YS
25/7/12	C D I	QC JM	F H L	LS JE			B D H I L M	YS
26/7/12	A C D I	QC MD	F H L	QC			B D H I L M	QI
27/7/12	A C D I	QC QC	F H L	LS QC			B D H I L M	QI
28/7/12	H C D I	MC MD	F H /	MD			B D H I L M	QI
29/7/12	A C D I	QC JM	F H	QC			B D H I L M	QI
30/7/12	A C D I	QC JM	F H	QM QC			B D I L M	MC
31/7/12	A C D I	YS	F H /	MD			B D H I L M	MC
1/8/12	A C B D	JM QC	F H	QC QR			B D H I L M	MC

OTHER TIMES

Code	Time	Intls	Code	Time	Intls	Code	Time	Intls

DEPOT INJECTION

Code	Intls

AS REQUIRED

Code	Time	Intls	Code	Time	Intls
WA	15.45	AC			
2	1810	AdAc			
2	1345	MC			
2	1835	MC			
2	1420	QC	2	22.20	QI
2	1820	QC			
2	1550	YS			
2	1255	LS JE			
2	1800	MC			
T	20.25	MC JM			
2	1405	JE			
2	1820	QC			
2	03.15	QI			
T	1620	NO AP			
2	1750	QC MC			
2	1910	MC			
U	22.00	QI			
2	715	MC			
U	21.55	MC			
2	745	QC JM			

COMMENTS ON DISCREPANCIES

D – Self admin
WA – 10ml 5 sml

D - Self Admin
2 - headache

D - Self admin

D - Self admin

D - Self admin

2 - Headache tablets

D = self admin
2 = 1g for headache
T - headache

D - Self admin
U - refused
T - Bone ache

D Self Admin

D - Self admin
2 - headache

D = Self admin
D - Self admin

D - Self Admin

D self admin

NAME: LEON GRATTON UNIT No: 1703755191 WARD: DUNDO

NB – A NEW RECORDING SHEET MUST BE TAKEN EACH TIME A PRESCRIPTION SHEET IS CHANGED

PRESCRIPTION SHEET No. 6

Kardex Rewritten 5.7.12

KEY
A DRUG REFUSED
A PATIENT ABSENT

MEDICINE RECORDING SHEET

REGULAR PRESCRIPTIONS

Date	8.00	Intls	13.00	Intls	18.00	Intls	22.00	Intls
5/7/12	A C D I		F H	AC			B E H D G I	SL
6/7/12	A C D I	SM	F H				B E H D G I	
7/7/12	A C D I	& AC	F H	SL			B E H D G I	
8/7/12	A I D	MC LMCT	F H	MK LMCT			B C H D G I	
9/7/12	A C D I	AC LMCT	F H	LMCT			B E H D G I	
10/7/12	A D E	SM MC	F H	SM			A B D C H I G	SL
11/7/12	A C D I	SL SM	F H	SL SM			B D G G H I	SL
12/7/12	A C D I	SM	F H	LS AC			B D E H I J	
13/7/12	A C O I	MC AC	F H	AC SM			B D E H I J	SL
14/7/12	A C O I	SM	F H	no LS			B D C H F J	
15/7/12	A C D I	AW AC	F H	AC			B D G H I J	LMCT
16/7/12	A C D I	SM	F H	SL SM			B D E H I J	
17/7/12	A C D I	SL	F H	LS SL			B D E H I J	
18/7/12	A I C D	MC SM	F H	MC LMCT			B D G H I J	SL

OTHER TIMES

Date	Code	Time	Intls	Code	Time	Intls	Code	Time	Intls
9/7/12	A	09.30	SM MC						
	C	09.30	SM MC						
	I	09.30	SM MC						

DEPOT INJECTION

Date	Code	Intls

AS REQUIRED

Date	Code	Time	Intls	Code	Time	Intls
5/7/12						
6/7/12	2	1810	LS AC			
7/7/12	Z	1455	SE			
8/7/12	U	15.50	AC			
	Z	15.50	AC			
9/7/12	Z	0635	JS	W(F)	2035	SM MC
	U	1250	LMCT			
	Z	1710	MC AC			
10/7/12	Z	0015	JS			
	Z	1805	LMCT			
11/7/12	Z	1805	SM	W(F)	2035	D = SELF admin W(F) = SMOKE
12/7/12	Z	18.45	MC			
13/7/12	U	1430	no			
	T	1645	no			
	Z	1815	LS			
14/7/12	Z	1255	MORS			
	Z	1910	LMCT			
15/7/12	Z	0850	JS	W(F)	1800	D=0
	W(F)	0950	JS			
	Z	1900	LS 10			
16/7/12	U	1220	JS	Z	1630	SE
	Z	0115	JS			
	U	1010	LMCT			
17/7/12	Z	1115	SE			
	Z	1800	AC SE			
18/7/12	Z	1530	SM	WF	2150	SL

COMMENTS ON DISCREPANCIES

- D SELF ADMIN 2200.
- D self admin
- D self admin
- D = self admin
- U - dec/gradient
- Z - headache
  D - self admin
  W(F) - SMOKE
- Z - bed Round
  D - Self Admin
  LA - SOLUBLE
- D = SELF admin W(F) - SMOKE
- D - Self admin
- P - Self Admin
- D - self admin
  * Neurodine.
- W(F) 10 MG
  Z SEE Round W(F) 10 MG Cough
- D Self admin
  D Self admin
- D = Self admin
- 2 - HEADACHE WF = 10 MG.

NAME: LEON GATTON UNIT No: 1703511941 DE WARD: DUNINO

NB – A NEW RECORDING SHEET MUST BE TAKEN EACH TIME A PRESCRIPTION SHEET IS CHANGED

PRESCRIPTION SHEET No. 5

KEY
DRUG REFUSED
PATIENT ABSENT

MEDICINE RECORDING SHEET

Date	REGULAR PRESCRIPTIONS 8.00	Intls	13.00	Intls	18.00	Intls	22.00	Intls	OTHER TIMES Code	Time	Intls	Code	Time	Intls	Code	Time	Intls	DEPOT INJECTION Code	Intls	AS REQUIRED Code	Time	Intls	Code	Time	Intls	COMMENTS ON DISCREPANCIES
28/6/12	B D E	NO AC	K L	AC AC			A C E J L	QS												2	11:50	NO				E Self Admin. Z headache
29/6/12	B D E	AC SJ	K L	QC			A C E J L	QS																		E - refused
30/6/12	B D E	MC NO.	K L	LS NO.			A C E J L	QS												2 2	09:30 LS 18:30 BC					E - Self Return. Z - HEADACHE
1/7/12	B D E	AC SJ	K	AC LS			A C E J L	QS																		E Self admin 6 Refused
2/7/12	B D E	NO MC	R	MC			A C E J L	QS												2	14:00	AC QS				E - Self Admin. Z - HEADACHE
3/7/12	B D E	AC	KPOE - OK.				C E JOP	AC												J 2	02:00 SJ. 18:05 AC NO					E Self admin Z. headache.
4/7/12	B D E	NO	NKPOE				C E J O P	QS												2 2	16:45 AC 21:35 SJ		21:00 WC SJ		QS	E Self Admin.
5/7/12	B D E	POE	F H LEAVE	AC LS			NEW ILLNESS													2 Y	15:20 NO 19:40 NO.					E Self admin. 2 Headache

NAME: LEON GRATTON UNIT No: 17035191 WARD: DUNINO

NB – A NEW RECORDING SHEET MUST BE TAKEN EACH TIME A PRESCRIPTION SHEET IS CHANGED

PRESCRIPTION SHEET No. 5

Rewritten 14/6

KEY
(A) DRUG REFUSED
(A) PATIENT ABSENT

MEDICINE RECORDING SHEET

REGULAR PRESCRIPTIONS

Date	8.00	Intls	13.00	Intls	18.00	Intls	22.00	Intls	OTHER TIMES Code	Time	Intls	Code	Time	Intls	Code	Time	Intls
14/6/12	//		//		//		A C E F	BS									
15/6/12	B D E F G	pen SV					A C E F G	BS									
16/6/12	B F D G E	AC AW					D C E F	MC									
17/6/12	B F G E	NO					D C E F	MC									
18/6/12	B E D G E	AC pm					A C E F G H	QC MC									
19/6/12	B D E G	QC pm					D C E G H	MC									
20/6/12	B D E G	pm AC					A C E H	BS									
21/6/12	B D E G	SM NM					A C E H	BS									
22/6/12	B D E I	NO SM					A C E H	BS									
23/6/12	B D E I	QC					D C E H	MC									
24/6/12	B D E I	QV AC					D C E H	MC									
25/6/12	B D E I	SM QV					D C E H	MC									
26/6/12	B D E	AC AC		K	AC QV		D C E H	MC									
27/6/12	B E	QC NC		K	QC LMT		A C E H	BS									

DEPOT INJECTION

Code	Intls

AS REQUIRED

Code	Time	Intls	Code	Time	Intls
2	0000	NS	Z	1800	CS AC
Z	1300	QV pm			
Z	1515	NO			
T	1855	NO.			
Z	1305	NO QV			
2	1750	AW AC			
U	0180	MC	Z	1800	
Z	13.00	QV			
Z	13.00	pm			
		QC			
Z	18.10	AC			
U	10.30	AC			
Z	1305	pm			
Z	1800	NO SM			
			Z	1315	AW
2	0525	NS			
U	15.35	QV			
T	1745	QC			
Z	17.55	AC			
U	0905	QV			
Z	1930	NS			
Z	17.55	AC			
4	2200	MC			
Z	14.00	AC			
Z	1810	ANSM			
4	0030	MC			
Z	18.25	AC			

COMMENTS ON DISCREPANCIES

Self adm
Continues N/K
Oxycodone qds

E – Self admin

E – Self admin
headache.

E – Self admin
headache.

E – Seg Admin
headache.

E – Not required.
Z – Refuses
Z Stat admin

E – Self admin

Z – headache

E – Self admin

headache.

2 – headache # above
E – self med
U – 20 mins

E – Self admin

E – Self admin

E – Self admin

E – Self admin

E – Self admin

E – Self admin

E – Self admin
Z – headache.

NAME: LEON GRATTON UNIT No: 17035 1191 WARD: Dunlin

NB – A NEW RECORDING SHEET MUST BE TAKEN EACH TIME A PRESCRIPTION SHEET IS CHANGED

PRESCRIPTION SHEET No. 4

KEY
(W) DRUG REFUSED
PATIENT ABSENT

MEDICINE RECORDING SHEET

REGULAR PRESCRIPTIONS

Date	8.00	Intls	13.00	Intls	18.00	Intls	22.00	Intls	OTHER TIMES Code	Time	Intls	Code	Time	Intls	Code	Time	Intls
9/6/12	B D L P	gm wo	L	gm wo			A L P	C / mc									
10/6/12	B D L	Q LMG	O	O LMG			A L P	C / mc									
11/6/12	B D L	P / AC wo	O	gm			A L P	C / mc									
12/6/12	B L	D P KW LS	O	QM LS			A L P	C / OB									
13/6/12	B L	D P KW QC	O	QC AC			A L P	C / OB									
14/6/12	B L	D P AM AC	O	QM gm													

DEPOT INJECTION

Code	Intls

AS REQUIRED

Code	Time	Intls	Code	Time	Intls
2	12.55	gm			
2	17.45	92 LMCT			
2	1259	QC LMCT	2	18.00	gm wo
T	0930	IM	4	1800	IM QC
U					
2	13.15	gm			
2	1015	W.			
2	1756	KW QC			
2	1300	QC			
2	1520	LS AC			
T	1905	LS AC			
U	2.05	W			
2	18.25	KW LS			

COMMENTS ON DISCREPANCIES

L – Self admin.

2 – headache
2 headache
L – self Admin.
L Self-admin
L Self admin

NAME: LEON GRATTON UNIT No: 1703751191 WARD: DUNDO

NB – A NEW RECORDING SHEET MUST BE TAKEN EACH TIME A PRESCRIPTION SHEET IS CHANGED

PRESCRIPTION SHEET No. 4

KEY
(A) DRUG REFUSED
(A) PATIENT ABSENT

MEDICINE RECORDING SHEET

REGULAR PRESCRIPTIONS

Date	8.00	Intls	13.00	Intls	18.00	Intls	22.00	Intls	OTHER TIMES Code	Time	Intls	Code	Time	Intls	Code	Time	Intls
26/5/12	B D L	MC Q	N /	no			A C K L	MC									
27/5/12	B D L	AC hwk	N	AC			A C K L	gm									
28/5/12	B D L	AC Q	N	Q			A C K L	QC									
29/5/12	B D L	MC SL	N	AC MC			A C K L	QC									
30/5/12	B D L	AC gm	W	gm			A C K L	QC									
31/5/12	B D L	LS	H	hwk			A C K L	MC									
1/6/12	B D L	AW AC	N	AC			A C K L	MC									
2/6/12	B D L	LS	N	LS			A C K L	MC									
3/6/12	B D L	AW gm	W	gm			A C K L	MC									
4/6/12	B D L	gm	N	L			A C K L	LS									
5/6/12	B D L	LS gm	N	AC gm			A C K L	LS									
6/6/12	B D L	LS MC	N	Gm			A C K L	LS									
7/6/12	B A L	QC LS	O	QC no			A C L P	LS									
8/6	B D L	QC MC	O	QC			A C L P	MC									

DEPOT INJECTION

Code	Intls

AS REQUIRED

Code	Time	Intls	Code	Time	Intls
Z	0040	MC			
Z	17.15	AC			
T	1600	no			
Z	1755	no Q			
T	1850	gm			
Z	06.15	gm			
Z	1445	AW			
Z	1935	MC			
Z	18.10	AC			
Z	1620	QC			
Y	1900	LS			
Z	2220	QC			
T	0105	QC			
Z	1820	AC			
Z	0400	MC			
Z	1805	LS			
Z	1210	AW			
Z	1650	MC			
T	1810	AW			
Z	08.20	AC			
Z	1735	QC			
T	1830	LS			
Z	1400	LS			
Y	1710	LS			
Z	15.40	MC			
Z	1810	gm			
Y	0830	LS MC			
Z	1605	AW no			
Y	1940	no			
Z	0915	QC LS			
Z	1505	QC			
T	1820	gm MC			
Z	1350	no			
Z	18.10	gm			
W(h)	1905	no			

COMMENTS ON DISCREPANCIES

L Self Admin

L self admin
T took gm late

L - self admin

L-Self admin

L – Self Admin

L Self admin

L – Self admin

L Self admin

L – Self admin

L Self admin

L – Self admin

L – Self admin
Z – headache
Y – Pain under draft

L – Self admin

P Commence 8/6
L – Self admin
P = Commence @ 2100 hrs
Z = headache
W(h) – psoriasis

NAME: LEON GRATTON UNIT No: 1753751191 WARD: QUINO

NB – A NEW RECORDING SHEET MUST BE TAKEN EACH TIME A PRESCRIPTION SHEET IS CHANGED

PRESCRIPTION SHEET No. 4

(A) KEY
(A) DRUG REFUSED
PATIENT ABSENT

MEDICINE RECORDING SHEET

Date	REGULAR PRESCRIPTIONS 8.00	Initls	13.00	Initls	18.00	Initls	22.00	Initls	OTHER TIMES Code	Time	Initls	Code	Time	Initls	Code	Time	Initls	DEPOT INJECTION Code	Initls	AS REQUIRED Code	Time	Initls	Code	Time	Initls	COMMENTS ON DISCREPANCIES
14/5/12	B D J	AC DJ	13.55 [illegible] 17.30 [illegible]	DJ			A C K L	QC												Y R 2	0115 845 10.10	QC AC DJ	2	1600	DC	Y Sore neck 2-1600 meds 2=headache
15/5/12	B D J	AC DC					A K C L	ND												2 2 2	13.25 18 IV	ML RDL				2-headache L Safe Admin.
16/5/12	D J	D L JM DC					A C K L	ND	L	0600	ND									T Y 2	0150 0440 1400	ND ND LS	2 U	0800 1635	SC DC LS	L-ankle pain Y-ankle pain S-cramp 2-headache
16/5/12																							S Y	2140 2215	ND ND	Y-knee pain.
17/5/12	B J	D L DJ					A C K L	ND.												2 2 Y	1245 1805 2135	LS QM DJ ND				L Self harming 2-1245-spasm in knee pain.
18/5/12	B J	D L JM LS					A C K L	ND												Z Y Z	0255 0255 1510	ND ND LS	Y 2	1640 2240	LS ND	Sore legs and knees 0255. Y 1640 knee pain L-Self harming L-Suspension 2-1510 headache. 2-2nd leg pain.
18/5/12																										
19/5/12	B J	D L JM LS					A C K L	QC												T S 2	0210 1800 1800	ND MC MC	S Y	2145 2255	QC QC	L Self-harm 2-knees + legs sore Y legs pain
20/5/12	B J	D L MC AC					A C K L	QC												Z Z U	10.55 18 15 1615	AC LS QJ LS				L-Self harming 2-sore legs 2-sore chest, U-dyspepsia
21/5/12	B J	D L LS					A C K L	gm												2 2 Y	0955 12.55 2025	LS AC JM				L Self harming
22/5/12	B	D L AM Q	M	QJ LS			A C K L	gm												~~Y~~ Y 2	~~0000~~ 0000 0900	~~QM~~ gm DC	2 Y 2	1550 1700 2330	LS AC gm	L Self harm 2-1550 headache Y-headache
23/5/12	B	D L BM DJ	M	MS			A K C L	MC												Z 2	1250 1810	DR LS tab				Z 1250 quiet 2-1800 chest pain
24/5/12	B	D L AM DC	N	AM QM			A C K L	LMC												Z 2 Y 2	0010 1645 1750 0030	MC LS NO LMC				L Self harm 2-1645 quiet Y quiet 2-1pm Bonuchen L-Self harm
25/5/12	B	B L MC DC	DC	MC			A C K L	MC												Z Z T	18.10 2215	QM MC				

NAME: LEON CRATTON UNIT No: 170375 1191 WARD: DUNINO

NB – A NEW RECORDING SHEET MUST BE TAKEN EACH TIME A PRESCRIPTION SHEET IS CHANGED

PRESCRIPTION SHEET No. 4

KEY
(A) DRUG REFUSED
(Ø) PATIENT ABSENT

MEDICINE RECORDING SHEET

REGULAR PRESCRIPTIONS

Date	8.00	Initials	13.00	Initials	18.00	Initials	22.00	Initials	OTHER TIMES Code	Time	Initials	Code	Time	Initials	Code	Time	Initials
30/4/12							A C E G	QJ									
1/5/12	B D C F	QJ					A C E G	QJ									
2/5/12	B D E F –	LS. SM					A C E G	QJ									
3/5/12	B D E F	AC NO.					A C G	QC									
4/5/12	(B) (D) (F) (H)	JMS					A C G	NO									
5/5/12	B D I	AW NO.					A C I	QC									
6/5/12	B D I	AC JMS					A C I	NO									
7/5/12	B D I	AC AW					A C I	MC									
8/5/12	B D I	NO QC					A C I	MK									
9/5/12	B D I	LMG JMS					A C I	MC									
10/5/12	B D A	QJ JMS					A C K	MC									
11/5/12	B D J L	LS QJ					A C K	QC									
12/5/12	B D J	MC QJ					A C K	QC									
13/5/12	B D J	AC QJ					A C K	QC									

DEPOT INJECTION

Code	Initials

AS REQUIRED

Code	Time	Initials	Code	Time	Initials
Z	1135	LS			
Z	1640	QM			
Y	1915	LS			
Z	1355	MC	Z	2255	QJ
U	1830	MK			
Z	1004	LS	Z	1755	QC
T	1635	QM			
Z	1800	MC AW			
Z	2225	QC			
Z	0430	QC			
‡	1810	NO AW			
Z	18.00	JMS AC			
Z	12.50	AC SM	Y	1550	QC NO
W(Ø)	1845	NO			
U	9.30	AC			
Z	0145	QC			
‡	1810	NO MC			
‡	1055	NO			
Y	1500	QJ LS			
Z	18.10	MK QJ			
Y	2220	MC			
Z	0115	MC			
Z	18.00	AC			
Z	1355	LS.			
Z	18.00	MC AW			
‡	1250	NO MK			
W(H)	2030	LS			
Z	2050	RS.			
R	9.00	AC	Z	17.50	QJ NO
Z	1255	MK	R	1850	NO
R	1340	LS			

COMMENTS ON DISCREPANCIES

- Y altho/Pain
- Z = headache.
- Z 1g paracetamol for headache 1755 QC
- Z = headache
- Z = headache. ‡ = headache.
- Z 1550 = headache. Was 20mg.
- Z Headache.
- ‡ headache.
- ‡ Headache = Y altho. Pain
- c/o sore head pain.
- Z - headache
- Z - back & knee pain (1g paracetamol 1135) 2 1g for headache.
- ‡ Body aches. 2 1g paracetamol for body aches.
- Z = sore head

NAME: Leon Gratton UNIT No: 170375 1191 WARD: Domino Ward

NB – A NEW RECORDING SHEET MUST BE TAKEN EACH TIME A PRESCRIPTION SHEET IS CHANGED

PRESCRIPTION SHEET No. 3

(2) 9 (2)

KEY
(A) DRUG REFUSED
(A) PATIENT ABSENT

MEDICINE RECORDING SHEET

Date	REGULAR PRESCRIPTIONS 8.00	Intls	13.00	Intls	18.00	Intls	22.00	Intls	OTHER TIMES Code	Time	Intls	Code	Time	Intls	Code	Time	Intls	DEPOT INJECTION Code	Intls	AS REQUIRED Code	Time	Intls	Code	Time	Intls	COMMENTS ON DISCREPANCIES
02/04/12																				R 2215 QC						
03/04/12																				R 2215 QC						
15/4/12																				R 21.50 QC						
22/4/12																				S 1745 AW QC						S-Headache
																				S 2225 NO						S-headache
23/4/12																				S 21.50 QC						S-right ache
																				S 18.00 AC JH						
24/4/12																							S 1500 QC NO			S-headache S-rig 1800 migraine.
																				S 8.55 MCMC						
																				S 12.55 MCMC						
25/4/12																				S 0945 NO						S-headache.
																				3S 1835 LS QC						
26/4/12							3B	QC												3S 1210 LS QC			3S 0850 QC			3S-right ache
																				3S 1705 LS						3S-Is headache.
																				3S 0950 LS						3S-headache
27/4/12	3A	AC					3B	QC												3S 0.50 QC						3S-headache @ 0.50hrs
		JH																		3S 9.10 AC JH						
																				3S 1535 JH						
28/4/12	3A	MC					3B	QC												3S 0315 QC						3S-headache.
		IO.																		3S 1340 LS						3S-Is paracetamol headache 1340
																				3S 2030 LS						
29/4/12	3A	AW					3B	QC												3S 1745 LS MC						3S-headache. 1g paracetamol
		AS																		3S 0						
30/4/12	3A	LS																		3S 06.45 LS						3S headache
		MC																								

NAME: LEON GRATTON UNIT No: 170375191 WARD: DUNLIN

STRATHCARN HOSPITAL

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

	REGULAR PRESCRIPTIONS																	DEPOT INJECTION		AS REQUIRED						COMMENTS ON DISCREPANCIES
									OTHER TIMES																	
Date	8.00	Intls	13.00	Intls	18.00	Intls	22.00	Intls	Code	Time	Intls	Code	Time	Intls	Code	Time	Intls	Code	Intls	Code	Time	Intls	Code	Time	Intls	

NAME: .... UNIT No: .... WARD: ....

1 of 2.

NB – A NEW RECORDING SHEET MUST BE TAKEN EACH TIME A PRESCRIPTION SHEET IS CHANGED

PRESCRIPTION SHEET No. 2

Ⓐ KEY
Ⓐ DRUG REFUSED
Ⓐ PATIENT ABSENT

MEDICINE RECORDING SHEET

Date	REGULAR PRESCRIPTIONS 8.00	Intls	13.00	Intls	18.00	Intls	22.00	Intls	OTHER TIMES Code	Time	Intls	Code	Time	Intls	Code	Time	Intls	DEPOT INJECTION Code	Intls	AS REQUIRED Code	Time	Intls	Code	Time	Intls	COMMENTS ON DISCREPANCIES
17/4/12	C E I K / /	LS OL	E	6pm OL	E	AC	A D E I	9C												✱	0015	no				✱ jaw pain.
18/4/12	C E I K	pm AC	E	6pm LS	E	no. LMT	A D E I	9C																		
19/4/12	C I E K	AW					A D L M	9C												Z	1805	6pm 9pm				
20/4/12	C K L L	8pm					A D L M	9C												Z Z	1550 1805	AW 6pm OL				2-Postmade
21/4/12	C K L	OL					A D L M	9.												Z	18.00	AC MC				
22/4/12	C K L L	LS AC					A D L M	no.												✱ Z	22.35 1300	no. MC				✱-headache headache-2
23/4/12	C K L	9m OL					A D L N	9.																		
24/4/12	C K L N	MC MC					A D L N	9.																		
25/4/12	C K L N	AW no.					A D L N	9C																		
26/4/12	C K L N	LS OL					2A 2D 20	9C												✱	1840	no.				✱-headache
27/4/12	2C 2K 20	AC MS					2A 2D 20	9C												U	1930	LS MC				
28/4/12	2C 2K 20	MC no.					2A 2D 20	9C																		
29/4/12	2C 2K 20	AW MS.					2A 2D 20	9.																		
30/4/12	2C 2K 20	LS MC																								

NAME: LEON GRATTON UNIT No: 170375191 WARD: DW0100 STRATHERE HOSPITAL

1 of 2.

NB – A NEW RECORDING SHEET MUST BE TAKEN EACH TIME A PRESCRIPTION SHEET IS CHANGED

PRESCRIPTION SHEET No. 2

(A) KEY
DRUG REFUSED
PATIENT ABSENT

MEDICINE RECORDING SHEET

Date	REGULAR PRESCRIPTIONS 8.00	Intls	13.00	Intls	18.00	Intls	22.00	Intls	OTHER TIMES Code	Time	Intls	Code	Time	Intls	Code	Time	Intls	DEPOT INJECTION Code	Intls	AS REQUIRED Code	Time	Intls	Code	Time	Intls	COMMENTS ON DISCREPANCIES
3/4/12	C E I K	AW	E	A	E	C MC	A D E I																			
4/4/12	C E I K	MC QC	E	MC	E	AW 10	A D E I													Z 0410 QC						Z-0410 Dental Pain
5/4/12	C I E K	NO	E	NO AW	E	MC	A D E I	MM QL												Z 1415 QC			Z 1735 AW			Z-Sore throat
6/4/12	C E I K	QC MC	E	QC	E	NO QB	A D E I	MM QL												Z 1415 MC						
7/4/12	C E I K	QB LMCT	E	QB	E	AW NO	A D C I	QL												Z 0240 QL						Z-dexter patch
8/4/12	C E I K	AW NO	E	NO AW	E	LMCT	A D C I	QL												↓ 1435 MS						↓ sore back & neck.
9/4/12	C E I K	QB LMCT	E	KC	E	AW QW	A D C I	QC	E	1210	QC									Z 0815 QC			Z 1830 QW			↓ sore back
10/4/12	C E I K	KC QW	E	KC QW	E	QW LS	A D C I	QC	E	2205	QC									Z 0325 QC						Z neck/back
11/4/12	C E I K	QW QC	E	QW QB	E	MC QB	A D E I	QC												Z 1400 LMCT						Z-back QL 1200
12/4/12	C I E K	AW AC	E	LS	E	MC QB	A D E I	QC												Z 1815 LS MK						E=Other Nurse @ 2202 LWJ
13/4/12	C E I K	QB	E	MC	E	LS AC	A D E I	QL												Z 0655 QC Error						Z Jaw pain Error
14/4/12	C E I K	QW LS	E	LS QW	E	MC AC	A D E I	QL												Z 0655 QC						Z-Jaw Pain.
15/4/12	C I E K	AC MC	E	AC	E	LWJ	A D E I	QL												Z 1410 LMCT						
16/4/12	C E I K	AW AC	E	QW AW		NO LS	A D E I	NO																		

NAME: Leadgeaton UNIT No: 170375111 91 WARD: OLW100 Stranded

NB – A NEW RECORDING SHEET MUST BE TAKEN EACH TIME A PRESCRIPTION SHEET IS CHANGED

PRESCRIPTION SHEET No. 2.

KEY
DRUG REFUSED
PATIENT ABSENT

MEDICINE RECORDING SHEET

Date	REGULAR PRESCRIPTIONS 8.00	Intls	13.00	Intls	18.00	Intls	22.00	Intls	OTHER TIMES Code	Time	Intls	Code	Time	Intls	Code	Time	Intls	DEPOT INJECTION Code	Intls	AS REQUIRED Code	Time	Intls	Code	Time	Intls	COMMENTS ON DISCREPANCIES
20/3/12	C K / E / I /	ND	E	QC	E	QC LMW	A D E I	AC												Z	01.35	GM				6 + 9/24 SOMIRO
21/3/12	C K E / I /	D. GM	E	ND. GM	E	QC MC	A D E I	AC																		
22/3/12	C E I K	MC QC	E	MC	E	AW GM	A D E I	AC												Z	16.15 LMW						
																				Z	23.45 AC						
23/3/11	C K I K	GM QC	E	MC QC	E	MC QC	A D E I	AC												Z	11.20 GM						Refusing
																				Z	23.40 AC						
24/3/12	C I E K	QC	E	QC MC	E	AW ND.	A D E I	GM															4	1625	to ND.		U - Agitation 2 neck ache.
																				Z	10.20 QC						& Toothache.
																				4	1510 ND						
25/3/12	C I E K	AW ND.	E	AW ND.	E	QC MC	A D E I	GM GM												Z	09.30 GM						
																				Z	25.20 QC						2 neck ache
26/3/12	C E I K	MC QC	E	QC LMW	E	ND.	A D E F	GM												Z	11.20 LMW						& Gompa.
																				4	1755 ND.						
27/3/12	C K / E / I /	ND MR	E	AC	E	QC AC	A D E F	GM												Z	07.25 GM						
																				4	1540 QC						
28/3/12	C E I K	AC MC	E	ND MR	E	QC	A D E I	QI												W	01.45 GM		Z	2010	QC		2 Dental Pain
																				Z	03.10 GM						& Is - Toothache
																				4	12.50 NOMC						
29/3/12	C E I K	QC LMW	E GM	QC	E	AC ND.	A D E I	QI												Z	12.55 GM						2 - Sore throat
																				4	1610 ND.						2 - sore jaw.
30/3/12	C I E K	AC QC	E	AC	E	QC MS	A D E I	QI												Z	00.45 QI		Z	22.40	QI		2 - toothache/jaw
																				21	03.50 QC						2 - back pain.
31/3/12	C I E K	MS QC	E	QC	E	MC GM	A D E I	QI												Z	21.50 QI						
1/4/12	E I K	MC AW	E	AW	E	MS	A D E I	GM												Z	1000 MS		Z Z	1050 21.45	GM		2 - toothache 2 - Pyrexia
2/4/12	C E I L	QC MS	E	QC	E	MC	A D E I	QC												Z	1130 MC						

NAME: [illegible] UNIT No: 170375191 WARD: Dunedin

NB – A NEW RECORDING SHEET MUST BE TAKEN EACH TIME A PRESCRIPTION SHEET IS CHANGED

PRESCRIPTION SHEET No. 2

(A) KEY
(A) DRUG REFUSED
PATIENT ABSENT

MEDICINE RECORDING SHEET

REGULAR PRESCRIPTIONS

Date	8.00	Intls	13.00	Intls	18.00	Intls	22.00	Intls	OTHER TIMES Code	Time	Intls	Code	Time	Intls	Code	Time	Intls	DEPOT INJECTION Code	Intls	AS REQUIRED Code	Time	Intls	Code	Time	Intls	COMMENTS ON DISCREPANCIES
6/3/12	C E I	AW MC	E	AW GM	E	AC QL	A E	D I	IVK											Z	1310	GM				
																				Z	20.30	AC QL				
7/3/12	C	C E I AC QL	E	AC QL	E	AW MC	A E	D I	MC											Z	9.35	AC				2 neck pain
																				Z	2035	QB				
8/3/12	C	E I QB	E	AW MC	E	QC QL	A	D E I	pm											W	0245	mc				
																				E	0235	mc				
9/3/12	C I	E K QL	E	QC QL	E	AW QC	A	D E I	pm											Z	01.55	pm				
																				Z	11.55	QL				2 - back pain
10/3/12	C I	E K QB QC	E	AW QMS	E	QC AC	A	D E I	pm											Z	18.50	AC				2-back pain
11/3/12	C E	I K QC AC	E	GM	E	QB	A	D E I	pm											Z	1430	QB				2 back pain
12/3/12	C F	E K AW QB	E	QB	E	AW AC	A C	D I	QL											Z	1630	AW				2 Back Pain +22.30.
																				Z	2230	QL				
13/3/12	C I	E K QC AC	E	AC AW	E	QB	A C	D I	QL																	
14/3/12	C E	I K AC QB	E	AC	E	QC	A C	D I	QL											Z	1710	MD				2 Back Pain. +22.30
																				Z	2230	QL				
15/3/12	C I	E K AW ND	E	ND	E	AW AC	A D K	I LMCT	E	1355	QC QL									Z	18.25	AC				
16/3/12	C I	E K AW AC	E	AC A	E	QC	A	D E I	pm											Z	1915	QC				2 - Back pain.
																				W	11.55	pm				
17/3/12	C I	E K QC QC	E	AW QC	E	ND QB	A	D E I	pm											Z	2025	MD				
18/3/12	C E I	K ND QB	E	QB	E	QC	A	D E I	pm											Z	2020	QC				2 - Arm pain
19/3/12	C I	E K QC	E	KP GM	E	QC LMCT	A	D E I	pm											Z	11.15	GM				2 spasm in 5000,
																				Z	1930	LMCT				

NAME: LEON GRATTON UNIT No: 12087511 WARD: DUNINO

NB – A NEW RECORDING SHEET MUST BE TAKEN EACH TIME A PRESCRIPTION SHEET IS CHANGED

PRESCRIPTION SHEET No. 2.

KEY
(A) DRUG REFUSED
(A) PATIENT ABSENT

MEDICINE RECORDING SHEET

REGULAR PRESCRIPTIONS

Date	8.00	Intls	13.00	Intls	18.00	Intls	22.00	Intls
21/2/12	B C G QC E E		E	MC	E	DM MC	A D E H	QDM
22/2/12	B C E G	QB	L	MC	E	DM Q	D C H	fem
23/2/12	B C E G	1M Q	E	M	E	QB	A D E I	fem
24/2/12	C E I J	QB	E	MB	E	QL	A D E I	fem
25/2/12	C E I J	AM QC	E	QC	C	QC	A D E	LMGT
26/2/12	C E I J	QC MC	E	QC	E	AM Q	A D E	I LMGT
27/2/12	C E I	QC Q	E	QC	E	QC MC	A D E	I LMGT
28/2/12	C E I	QB	E Q	E	E	QC MC	A D E	I ND.
29/2/12	C E I J	AM MC	E L	MC	E L	QC MC	A D E	I fem
1/3/12	C E I	MC QB	E L	MC	C	QC MC	A D E	I fem
2/3/12	C E I	QC QB	E	QB	E	AC Q	A D E	I fem
3/3/12	C E I	AC Q	Ø	AC	E	LMG	A D E	I fem
4/3/12	C E L	Q LMG	E	Q LMG	E	AC	A D E	I ND
5/3/12	C C I	Q QC		Q	E	AC MC	E	D I

DEPOT INJECTION

Code	Intls

AS REQUIRED

Code	Time	Intls
W	1765	DM MC MB
T	1925	
W	07.00	fem
W	0230	LMGT
T	0005	LMGT
T	0800	QC Q
W	09.00	fem
U	19.30	AC
Z	1025	QC
Z	1650	AM
Z	2305	MF

Code	Time	Intls

OTHER TIMES

Code	Time	Intls
E	2200	ND.
E	13.00	AC
E	2230	ND

COMMENTS ON DISCREPANCIES

(5) discontinued

T-Bree Pain

E-back Bruise pain

NAME: LEON GLATTON UNIT No: 1703751191 WARD: DUNIRO – STRATHGOGH HOSPITAL

NB – A NEW RECORDING SHEET MUST BE TAKEN EACH TIME A PRESCRIPTION SHEET IS CHANGED

PRESCRIPTION SHEET No. 2.

KEY
(A) DRUG REFUSED
(A) PATIENT ABSENT

MEDICINE RECORDING SHEET

Date	REGULAR PRESCRIPTIONS 8.00	Intls	13.00	Intls	18.00	Intls	22.00	Intls	OTHER TIMES Code	Time	Intls	Code	Time	Intls	Code	Time	Intls	DEPOT INJECTION Code	Intls	AS REQUIRED Code	Time	Intls	Code	Time	Intls	COMMENTS ON DISCREPANCIES
7/2/12						MH DM MC	A D C F													Y 1705 DM U 1905 DM			Y2 1250			
8/2/12	B C E F	MC ML	E	Q MC	E	MS	A D E F													Y 2215						
9/2/12	B C E F	AC DM	E	AC DM	E	CM MC	A F D E	NO.	E	2205	NO.									T 1715	GM				(T)	NEADPENE
10/2/12	B C E F	MH MC	E	DM	E	MH AC	A F D E	NO	E	2200	NO.									W 0955 T 0410	NO. NO.		U	12.10	MC	Headache
11/2/12	B C E F	MH AC	E	RD Mdt	E	MC Q	A F D E	NO.	E	2200	NO.									U 2310	NO					
12/2/12	B C E F	AC MC	E	Q	E	MH AC	A F D E	NO	E	2200	NO									W 1020 U 2340	MC NO.					
13/2/12	B C E F	AC RD	E	AC	E	MC	A D F E	MC																		
14/2/12	B C E F	AC MH.	E	AC AC	E	MC Q	A D E F	M2																		T-headache
15/2/12	B C E F	AC MC	E	AC Q	E	AC RD	A D E F	MC				E	1330	LWOT						T 0515	MC					
16/2/12	B C K F	AC LWOT	E	LWOT	E	AC Q	A D E H	MC												U 0110 XH 0110	MC MC					Whp sore lip
17/2/12	B C E G	AC Q	E	AC RD	E	QC QB	A H D E	MC	E	2200	NO.									U 0255 U 1550	MC MC					
18/2/12	B C E G	MC GM	E	MC	E	MC AC	A H D E	NO.																		
19/2/12	B C E G	MC GM	E	GM	E	QC QB	A H D E	NO.	D E	2300 2300	NO NO.									W 0100	NO.				(J)	Notrn Stock.
20/2/12	B C E G	RD GM	E	MC	E	QC MC	D H E	L	C	2220	NO.									U 2015	MC					

NAME: LEON GRATTON UNIT No: 1703751191 WARD: DUNING

NB – A NEW RECORDING SHEET MUST BE TAKEN EACH TIME A PRESCRIPTION SHEET IS CHANGED

PRESCRIPTION SHEET No. 1

Ⓐ KEY
Ⓐ DRUG REFUSED
PATIENT ABSENT

MEDICINE RECORDING SHEET

Date	REGULAR PRESCRIPTIONS 8.00	Intls	13.00	Intls	18.00	Intls	22.00	Intls	OTHER TIMES Code	Time	Intls	Code	Time	Intls	Code	Time	Intls	DEPOT INJECTION Code	Intls	AS REQUIRED Code	Time	Intls	Code	Time	Intls	COMMENTS ON DISCREPANCIES
6/12	B C F H	MC Q1	F	DM Q1	F	pm nit.	A C F H	Q1																		
7/12	B C F H	mc pm																								

NAME: LEONG GRATTON UNIT No: 1703751191 WARD: DUNDEE STRATHEDEN HOSPITAL

NB – A NEW RECORDING SHEET MUST BE TAKEN EACH TIME A PRESCRIPTION SHEET IS CHANGED

PRESCRIPTION SHEET No. 1

KEY
(A) DRUG REFUSED
(A) PATIENT ABSENT

MEDICINE RECORDING SHEET

REGULAR PRESCRIPTIONS

Date	8.00	Intls	13.00	Intls	18.00	Intls	22.00	Intls	OTHER TIMES Code	Time	Intls	Code	Time	Intls	Code	Time	Intls
23/1/12	B C F L	MH.		MH.	F	gm Ac	A D E F										
24/1/12	B C F G	MC MH.	F	AC	F	gm	A F B G E	NO.									
25/1/12	B G C F	QC AC	F	AC	F	gm DM	A F D G C	NO				F	0900	QC			
26/1/12	B G C F	MC	F	gm LMCT	F	DM	A C E H F	NO.									
27/1/12	B C F G H	MC	F	gm	F	MC LMCT	A E F	NO									
	B C F H	gm QC	F	QC DM	F	QC DM	A E F H	NO									
28/1/12	B C F H	QC	F	QC DM	F	MC gm	A E F H	NO									
29/1/12	B C F H	MC gm	F	QC		QC MC	A E F H	NO									
30/1/12	B C F H	AC MC	F	gm QC	F	AC MC	A E F H	NO.	F	2205	NO.						
31/1/12	B C F H	AC MC	F	DM AC	F	MH. QC	A E F H	NO.	F	2200	NO.						
1/2/12	B C F H	MH.	F	MH.	F	AC MC	A E F H	NO.	H.	1035	MH.						
2/2/12	B C F H	MC AC	F	AC	F	gm MC	A E F H	NO.	F	2205	NO.						
3/2/12	B C F H	MC	A	MC	F	MH. gm	A E F H	NO	F	1330	QC						
4/2/12	B C F H	MC MH. gm	F	MH.	F	MC QC	A E F H										
5/2/12																	

DEPOT INJECTION

Code	Intls

AS REQUIRED

Code	Time	Intls	Code	Time	Intls
W	1605	MC			
W	0410	NO.	Ra	1700	
W	2110		Ra	2305	NO
Ra	0630	NO			
W	1230	GM			
Y	0100	NO.			
W	1905	QC	X	2240	QC
W	0335		Y	2335	QC
X	1600	MC			
W	1630	MC			
X	0050	NO			
W	1715	MC			
X	[redacted]	NO			
W	0605	NO			

COMMENTS ON DISCREPANCIES

W – joint pain

X – short term

W – pain in foot + back. Ra – Comm

Ra – 20mls

W = Lpn Pain

G declined

W = backache

W – back ache / neck

W – sore back

H – NOTIFIED EXPIRED.

H – WITNESSED BY DOCTOR.

W – tooth pain

NAME: [redacted] UNIT No: 1703751101 WARD: Dundee Strathmiglo Hospital AMRI 57

NB – A NEW RECORDING SHEET MUST BE TAKEN EACH TIME A PRESCRIPTION SHEET IS CHANGED

PRESCRIPTION SHEET No. 1 (STRATHCLYDE)

KEY
(A) DRUG REFUSED
(A) PATIENT ABSENT

MEDICINE RECORDING SHEET

REGULAR PRESCRIPTIONS

Date	8.00	Initls	13.00	Initls	18.00	Initls	22.00	Initls	OTHER TIMES Code	Time	Initls	Code	Time	Initls	Code	Time	Initls
9/1/12	B C F	MH	F	MH QC	F	DM	A D E F	MC									
10/1/12	B C F	ND	F	MH ND	F	GM QL	A D E F	MC									
11/1/12	B C F	QL GM	F	QB	F	AW ND	A D E F	MC									
12/1/12	B C F	QC ND	F	GM ND	F	QL CMG	A D E F										
13/1/12	B C F	QL	Issued in Cellular Pharmacy F	QC	F	DM MH	A D E F		AD E F								
14/1/12	B C F	MH DM	F	MH	F	GM AW	A D E F										
15/1/12	B C F	AW GM	F	GM	F	DM	A D E F										
16/1/12	B C F	GM	R	QB	F	GM DM	A F D E	ND									
17/1/12	B C F	DM	F	GT DM	F	QB	A F D E	ND									
18/1/12	B C F	AW QL	F	QL	F	MC QC DM GM	A F D E	ND									
19/1/12	B C F	MC	F	QB	F	DM GM	A F D E	ND									
20/1/12	B C F	GM DM	F	NM QL	F	MC QC	A D E F										
21/1/12	B C F	AW MH	F	MH	F	AW	A D E F										
22/1/12	B C F	AW MC	F	MC	F	AW QC	A D E F										

DEPOT INJECTION

Code	Initls

AS REQUIRED

Code	Time	Initls	Code	Time	Initls	COMMENTS ON DISCREPANCIES
W	1405	MH				N-HEADACHE.
W	19.45	GM				
W	02.45	MC				W - headache/toothache
W	1930	ND				(BCF)
W	1015	GT				
W	2325	GM				W. Pains
W	1710	DM				
W	1645	AW				W. Joint pain
W	2020	DM				
W	0235	QC				W - JOINT PAIN
W	1105	QB				W - BNF ribs
W	1400	QB				1300 for Clexane
RA	1435	GM				W - Joint pain
RA	2135	ND				RA - DY-Morphine
W	1050	QL				W - rib/knee pain
RA	1245	QL				RA - diarrhoea
W	1715	MH				20 mls
X	1435	DM				N - RIB PAIN
X	1260	DM QL				
W	1345	MH	RA	2155	QC	W - Back Pain.
W	2000	AW				AW - Knee, joint
W	1350	MC				(A)
N	2020	MH				N 2220 - Headache

NAME: LEON GRATTON UNIT No: L703751191 WARD: DUNNO STRATHEDEN HOSPITAL

NB – A NEW RECORDING SHEET MUST BE TAKEN EACH TIME A PRESCRIPTION SHEET IS CHANGED

PRESCRIPTION SHEET No.

Admitted Dunning 06/01/12 1415

KEY
(A) DRUG REFUSED
(Ⓐ) PATIENT ABSENT

MEDICINE RECORDING SHEET

REGULAR PRESCRIPTIONS

Date	8.00	Initials	13.00	Initials	18.00	Initials	22.00	Initials	OTHER TIMES Code	Time	Initials	Code	Time	Initials	Code	Time	Initials
26/12/11	B C F	WW SC	F	WW SC	F		A D E F	CS DMG									
27/12/11	B C F	AM GD	F	GD AM	F	SC WW	A D E F	CS									
28/12/11	B C F	AM GD	F	LP WW	F	WW SC	A D E F										
29/12/11	B C F	AS WW	(F)	GD AM	F	GD RB	A D E F	W									
30/12/11	B C F	WW GD	F	WW AS	F	AM RM	A D E F	KJ AF									
31/12/11	B C F	AS RM	(F)	AM AS	F	AB LP	A D E F	KJ AF									
1/1/12	B C F	AS LP	F	LP	F	AM AS	A D E F	KJ RM									
2/1/12	B C F	AM LP	F	AM VL	F	AS RM	A D E F	AF									
3/1/12	B C F	RM AS	(F)	RM AS	F	AM LP	A D E F	D AF									
4/1/12	B C F	HG LP	F	AB IS	F		A D E F	AF DC									
5/1/12	B C F	GD	F	SP MP	F	LP IS	A D E F	SP DC									
6/1/12	B C F	IY RB	F	HS	F	AM MC	A D E F										
7/1/12	B C F	AM RM	F			MC RM	A D E F										
8/1/12	B C F	MH MC	F	MC	F	RM JS	D A E F	MC									

DEPOT INJECTION Code	Initials

AS REQUIRED

Code	Time	Initials	Code	Time	Initials
W	1415	HH GD			
W	07.00	GD			
W	16.40	AM			
W	15	WW			
W	0450	RM			
W	18.35	GD			
W	0615	AM			
W	1845	RM			
W	0640	KJ			
W	2340	AF			
W	1455	RM			
W	0230	KJ			
W	1700	RM AS			
W	1840	JP			
W	02:10	KJ			
W	1905	GD			
W	23.00	SP			
W	1945	JS			
W	1845	MC			
W	1350	MC MH			
W	1840	RM			

COMMENTS ON DISCREPANCIES

(E) – Nil Stock Error

(F) – asleep @ 1300hrs

W – sore head

W – Hemorrhage

NAME: LEON GRATTON UNIT No: 170375 1191 WARD: TWO

OCCUPATIONAL THERAPY SERVICE
MENTAL HEALTH

NHS Fife

NON-STANDARDISED ASSESSMENT

Name: Leon Gratton	Ward ☒ Day Hospital ☐ Rehab ☐ Community ☐
CHI No: 1703751191	**GP Name:** Dr D Garmany
Address: 85 Spittalfield Road, Inverkeithing	**Address:** Inverkeithing Medical Centre, 5 Friary Court, Inverkeithing
Telephone: 07922 56497	**Telephone:** 413234
Marital Status: -	**Next of Kin/Contact:** -
Consultant: Dr P Cavanagh	**Relationship:** -
	Telephone: -

Task Description and Environment:
Leon shopped for ingredients for and made macaroni cheese from scratch in the OT kitchen.
Persons present: Leon and Susan Haynes, Occupational Therapist

Mental State/Physical:
Leon reported feeling tired as he had only slept a few hours. Motivated to attend session. Difficulty concentrating at times. Mood was reactive. Leon's over estimates his own abilities.

Self Presentation:
Dishevelled and unkempt in personal appearance.
Friendly in manner.

Medical/Physical Factors:
None encountered during session.

FACTORS IDENTIFIED FROM ASSESSMENT – INCLUDING RISK:

- Able to identify and shop for required ingredients with some assistance
- Able to sequence task independently
- After initial orientation to kitchen was able to locate items independently
- Asked for assistance when appropriate
- Easily distracted from task by conversing with therapist
- After initial prompting regarding hand washing maintained reasonable standards of hygiene
- Required prompting to restore items to original places following task
- Turned off cooker unprompted, but after a short delay whilst draining pasta

Continued

SUMMARY AND RECOMMENDATIONS:

Leon has clearly developed kitchen skills in the past. However, Leon over-estimates his current skills. At present he requires some assistance to complete ADL tasks due to deficits in processing skills.

Recommendations
Leon will benefit from continued meal-making sessions. An AMPS assessment is planned to provide baseline information and scores.

Occupational Therapist's Signature: Susan Haynes	**Date:** 08/12/2011
Name: Susan Haynes	
Address: OT Department (Mental Health), Phase 1, Queen Margaret Hospital Whitefield Road, Dunfermline, KY12 OSA	
Telephone: 01383 - 674153	

Copies to:

GP	☒	CPN	☐	Other:	☐
OT	☒	Home Care	☐		
Nursing	☒	Social Worker	☐		
Consultant	☒	Community OT	☐		

OCCUPATIONAL THERAPY SERVICE
MENTAL HEALTH

NHS Fife

DISCHARGE SUMMARY

Name: Leon Gratton	Ward ☒ Day Hospital ☐ Rehab ☐ Community ☐
CHI No: 1703751911	**GP Name:** Dr D Garmany
Address: 85 Spittalfield Road, Inverkeithing	**Address:** Inverkeithing Medical Centre, 5 Friary Court, Inverkeithing
Telephone: 0792 256497	**Telephone:** 413234
Marital Status: Unknown	**Next of Kin/Contact:** Lorna Gratton
Consultant: Dr P Cavanagh	**Relationship:** Mother
	Telephone: 07762 602112

IDENTIFIED AREA OF NEED

Treatment Plan	Specified Assessments/Treatment	Achieved		
		Yes	No	In-part
Goal 1 To assess Leon's functional level	- Kitchen assessment - AMPS	☐	☐	☒
Goal 2 To maintain meal-making skills and interest in cooking	- Participation in 1:1 meal preparation/ shopping sessions - Meal-making group	☐	☐	☒
Goal 3		☐	☐	☐
Goal 4		☐	☐	☐
Goal 5		☐	☐	☐
Goal 6		☐	☐	☐
Goal 7		☐	☐	☐

OCCUPATIONAL THERAPY SERVICE
MENTAL HEALTH

NHS Fife

Summary and Recommendations

Prior to transfer to rehab at Stratheden, Leon was well-motivated to engage in a kitchen assessment and breakfast preparation session.

He required minimal prompting to attend to hygiene (hand washing) and to the tasks but displayed enjoyment and pride in his achievements.

Follow-up:

- OT referral from rehab ward
- Would benefit from AMPs to establish baseline for rehab

Occupational Therapist's Signature: B. Shaw	**Date:** 18.01.12
Name: Babs Shaw	
Address: Adult OT Mental Health, Queen Margaret Hospital, Phase 1, Whitefield Road, Dunfermline KY12 0SU	
Telephone: 01383 674153	

Copies to:

GP	☐	CPN	☐	Other:	☒
OT	☒	Home Care	☐	Karen Smart (FAO Rehab OT)	
Nursing	☐	Social Worker	☐		
Consultant	☒	Community OT	☐		

Dr Cavanagh

OCCUPATIONAL THERAPY SE
MENTAL HEALTH

for 6 week intervals
f.A-O Milly-20

STANDARDISED ASSESSM

Name:	Leon Gratton	Ward ☐ Day Hospital ☐ F	
CHI No:	1703751911	**GP Name:**	
Address:	C/O Dunino Ward, Stratheden Hospital, Cupar, Fife, KY15 5RR.	**Address:**	
Telephone:	01334 696227	**Telephone:**	
Marital Status:	Divorced	**Next of Kin/Contact:**	
Consultant:	Dr Dasgupta	**Relationship:**	
Date of Assessment:		**Telephone:**	

Location: Ceres Centre, Stratheden Hospital, Cupar, Fife, KY15 5RR.	**People Present:** Leon Gratton (Patient) Bill Booth (Occupational Therapist)

ASSESSMENT NAME:
Allen Cognitive Lacing Screen – 5 (ACLS-5)

About the Assessment:
The Allen Cognitive Level (ACL) is a leather lace screening tool, designed to assist in defining patient's presenting functional abilities and difficulties - i.e. in activities of daily living (ADL). The use of the ACL does not rely on verbal responses or reading and writing skills. The score ranges from Level 6 where functioning is deemed normal; and no intervention is required, to Level 1; where the person is assessed as profoundly impaired. The Screen Score observed at the time of assessment is; as noted a screen, and therefore will require additional assessment within the appropriate settings of ADL. ADL functional scores can be provided in abilities with grooming, dressing, bathing, walking/exercising, eating, taking medication, housekeeping, preparing and obtaining food, spending money and travelling. The ACL can be used with all adult groups.

Score:

On this occasion, Leon was observed to score a 4.8 indicating:-

A need for 26% cognitive assistance – the person can live alone with daily assistance to monitor safety and check problem solving effectives. The person may be able to attend a regular well rehearsed community activity without assistance.

With regards to bathing and grooming, a 4.8 indicates an ability to initiate and co-ordinate bathing routine. Independent with grooming, following routines and old habits.

With regards to dressing, a 4.8 indicates an ability to initiate dressing, although may not attend to certain aspects such as cleanliness of item, general fit etc. May don items slowly. Has capacity to learn donning new items, e.g. prosthesis following a rote of sequential practise.

With regards to walking and exercising, 4.8 indicates an ability to vary routes within familiar neighbourhood to reach destinations associated with routine activities. Scans visible environment to search for a desired cue, landmark etc. to guide direction. May learn new route by rote practised over several days. Reads street signs and attempts to use this information in guiding route, but still may be unable to find way home if lost. Understands risk elements of walking on own, especially at night etc.

With regards to planning/preparing for and eating food, 4.8 indicates an inability to plan for long term food needs, going to shop repeatedly and buying for immediate use only. May however have the ability to learn how to plan for planning a well balanced diet, purchasing certain items etc. through supported practise. – may follow a weekly schedule more effectively. May have ability to memorise a new sequence of actions required for preparing a new dish, following a rote of practising one stage at a time. May require assistance in following a recipe. Will clean up after with cues in line with social standards. With guided practise and support, may have ability to learn safety techniques required with cooking, managing open flames, using sharp items etc. Closely watches clock to time dishes for short periods; needs cues such as timer for longer periods.

With regards to eating, eats and attends to social conversation, and may not talk and eat at same time. Manages all utensil use.

With regards to toileting, 4.8 indicates an ability to be independent, noting all striking cues in new environment to locate a bathroom.

With regards to using adaptive equipment, 4.8 indicates an ability to recognise loss of range of motion, strength etc. and may have ability to learn use of new equipment by rote and supervised practise.

With regards to taking medication, 4.8 indicates an ability to follow prescriptions slowly. Can manage co-ordinating variables required in taking tablets, but with difficulty. Will follow verbal explanations of secondary effects to be avoided such as mixing medications etc.

With regards to housekeeping, 4.8 indicates an ability to initiate and complete a routine of housekeeping activities at the usual time of day. Learns new procedures slowly by rote.

With regards to spending money, 4.8 indicates a an ability to slowly follow a budget by rote, or learn money management recognised by others. May need assistance to adjust changes in income, expense, or usual banking procedures etc. and in managing emergencies such as stolen money or credit cards.

With regards to shopping, 4.8 indicates an ability to shop for routine items in familiar locations. Learns directions to new shopping areas by rote. May learn to use a shopping list, or use money saving coupons etc. from others through supervised practise. Such procedures are followed rigidly. May be able to learn safety precautions to protect against theft. When buying items, can identify price and size, however may not consider practicalities and cost.

With regards to travelling, 4.8 indicates an ability to learn a new route or travel procedure slowly by rote and supervised practise. May follow safety precautions pointed out by others, but may not anticipate potential hazards. If allowed to drive a motor vehicle, may do so slowly, or dangerously, unable to anticipate and react quickly to the movement of others.

With regards to using the telephone, 4.8 indicates an ability to learn use of new telephone, answering machine, pay phone etc. by rote. May need assistance to adjust to changes in new telephone procedures, new technologies etc.

RECOMMENDATIONS:
On the basis of this assessment, Leon would appear to demonstrate independence in many spheres of function. He would be ultimately able to maintain a tenancy in functional terms, and maintain ADL routines also. He would require background supervision and monitoring as he has a history of self-neglect and disorganisation against poor motivation when unwell. Please see complimentary non-standardised assessment.

Occupational Therapist's Signature:	**Date:** 2 / 2 / 12
Name:	Bill Booth
Address:	OT Adult Service, Ceres Centre, Stratheden Hospital, Cupar, Fife, KY15 5RR.
Telephone:	01334 696227

Copies to:

GP	☐	CPN	☐	Other:	☐
OT	☐	Home Care	☐		
Nursing	☐	Social Worker	☐		
Consultant	☐	Community OT	☐		

OCCUPATIONAL THERAPY SERVICE
MENTAL HEALTH

NHS Fife

NON-STANDARDISED ASSESSMENT

Name:	Leon Gratton	Ward ☐ Day Hospital ☐ Rehab ☐ Community ☐	
CHI No:	1703751911	**GP Name:**	
Address:	C/O Dunino Ward, Stratheden Hospital, Cupar, Fife, KY15 5RR.	**Address:**	
Telephone:	01334 696214	**Telephone:**	
Marital Status:	Divorced	**Next of Kin/Contact:**	
Consultant:	Dr Dasgupta	**Relationship:**	
		Telephone:	

Task Description and Environment:

- Shopping and errand running in Cupar town centre via private car to encompass budgeting, shopping, use of resources and road safety.
- Snack preparation/cooking in OT Kitchen at Ceres Centre to assess functional skills, safety and hygiene.

Mental State/Physical:

Leon engaged in conversation spontaneously and responded appropriately to comments and queries. He did not appear anxious or ill-as-ease at any point, despite voicing apprehension about 'bumping into' people in Cupar. He made one indirect reference to Madeleine; however, it was regarding where he could buy the book about her disappearance. Leon appeared physically fit.

Self Presentation:

Leon presented as motivated to engage in the assessment and maintained a pleasant and amenable demeanour throughout. He remained appropriate in his interactions with others; e.g., shop staff.

Medical/Physical Factors:

No significant limitations.

FACTORS IDENTIFIED FROM ASSESSMENT – INCLUDING RISK:

Leon presented as functionally able and competent as regards the above tasks; however, he omitted to wash his hands before handling raw meat and attempted to handle a hot grill pan unnecessarily without the use of; e.g., an oven glove. These omissions appeared to be due to a cavalier approach to tasks rather than a lack of awareness. Otherwise, Leon prepared a snack of bacon rolls and coffee competently and without guidance or prompting.

SUMMARY AND RECOMMENDATIONS:
Regarding this assessment, Leon presented as functionally able and competent. He followed his own routine of first visiting the Post Office, followed by a small shop and the supermarket, choosing his preferred purchases, all of his own volition. He had no difficulty orientating to unfamiliar locations and environments and was generally able to maintain safety. He would not require specific OT intervention with the above; however, he would benefit from on-ward self-catering to maintain skills. He may engage with OT for preferred activity in due course at the end of this assessment period.

Occupational Therapist's Signature:	**Date:** 2 / 2 / 12
Name:	Bill Booth
Address:	Adult OT Service, Ceres Centre, Stratheden Hospital, Cupar, Fife, KY15 5RR.
Telephone:	01334 696227

Copies to:

GP	☐	CPN	☐	Other:	☐
OT	☐	Home Care	☐		
Nursing	☐	Social Worker	☐		
Consultant	☐	Community OT	☐		

OCCUPATIONAL THERAPY SERVICE
MENTAL HEALTH

NHS Fife

STANDARDISED ASSESSMENT

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Telephone:	01334 696227	**Telephone:**	
Marital Status:	Divorced	**Next of Kin/Contact:**	
Consultant:	Dr Dasgupta	**Relationship:**	
Date of Assessment:		**Telephone:**	

Location: Ceres Centre, Stratheden Hospital, Cupar, Fife, KY15 5RR.	**People Present:** Leon Gratton (Patient) Bill Booth (Occupational Therapist)

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RECOMMENDATIONS:
On the basis of this assessment, Leon would appear to demonstrate independence in many spheres of function. He would be ultimately able to maintain a tenancy in functional terms, and maintain ADL routines also. He would require background supervision and monitoring as he has a history of self-neglect and disorganisation against poor motivation when unwell. Please see complimentary non-standardised assessment.

Occupational Therapist's Signature:	**Date:** 2 / 2 / 12
Name:	Bill Booth
Address:	OT Adult Service, Ceres Centre, Stratheden Hospital, Cupar, Fife, KY15 5RR.
Telephone:	01334 696227

Copies to:

GP	☐	CPN	☐	Other:	☐
OT	☐	Home Care	☐		
Nursing	☐	Social Worker	☐		
Consultant	☐	Community OT	☐		

OCCUPATIONAL THERAPY SERVICE
MENTAL HEALTH

NHS Fife

NON-STANDARDISED ASSESSMENT

Name:	Leon Gratton	Ward ☐ Day Hospital ☐ Rehab ☐ Community ☐	
CHI No:	1703751911	**GP Name:**	
Address:	C/O Dunino Ward, Stratheden Hospital, Cupar, Fife, KY15 5RR.	**Address:**	
Telephone:	01334 696214	**Telephone:**	
Marital Status:	Divorced	**Next of Kin/Contact:**	
Consultant:	Dr Dasgupta	**Relationship:**	
		Telephone:	

Task Description and Environment:

- Shopping and errand running in Cupar town centre via private car to encompass budgeting, shopping, use of resources and road safety.
- Snack preparation/cooking in OT Kitchen at Ceres Centre to assess functional skills, safety and hygiene.

Mental State/Physical:

Leon engaged in conversation spontaneously and responded appropriately to comments and queries. He did not appear anxious or ill-as-ease at any point, despite voicing apprehension about 'bumping into' people in Cupar. He made one indirect reference to Madeleine; however, it was regarding where he could buy the book about her disappearance. Leon appeared physically fit.

Self Presentation:

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Medical/Physical Factors:

No significant limitations.

FACTORS IDENTIFIED FROM ASSESSMENT – INCLUDING RISK:

Leon presented as functionally able and competent as regards the above tasks; however, he omitted to wash his hands before handling raw meat and attempted to handle a hot grill pan unnecessarily without the use of; e.g., an oven glove. These omissions appeared to be due to a cavalier approach to tasks rather than a lack of awareness. Otherwise, Leon prepared a snack of bacon rolls and coffee competently and without guidance or prompting.

SUMMARY AND RECOMMENDATIONS:
Regarding this assessment, Leon presented as functionally able and competent. He followed his own routine of first visiting the Post Office, followed by a small shop and the supermarket, choosing his preferred purchases, all of his own volition. He had no difficulty orientating to unfamiliar locations and environments and was generally able to maintain safety. He would not require specific OT intervention with the above; however, he would benefit from on-ward self-catering to maintain skills. He may engage with OT for preferred activity in due course at the end of this assessment period.

Occupational Therapist's Signature:	**Date:** 2 / 2 / 12
Name:	Bill Booth
Address:	Adult OT Service, Ceres Centre, Stratheden Hospital, Cupar, Fife, KY15 5RR.
Telephone:	01334 696227

Copies to:

GP	☐	CPN	☐	Other:	☐
OT	☐	Home Care	☐		
Nursing	☐	Social Worker	☐		
Consultant	☐	Community OT	☐		

Mental Health Directorate

ADMISSION INFORMATION SHEET [A1-1]

NHS

Initial admission to Ward/Department Dunino	Community Service/Hospital: Stratheden	Admission to Hospital: Date: 06.01.12 Time: 1415
Consultant: Dr Dasgupta	Named Nurse/Case Manager: Shona Napier	Unit No/CHI No: F5153833/1703751191
		Care Programme Approach No:

Personal Information

FULL NAME: Mr / Mrs / Ms / Miss / Master Mr Leon Gratton	Where appropriate, likes to be known as: Leon	Previous or Maiden Name(s): n/a
	Date of Birth: 17.03.75 Gender: Male	Place of Birth: Manchester
Home Address: 85 Spittalfield Road verkeithing Post Code: KY11 1DZ	Current Address: c/o Dunino Ward Stratheden Hospital Cupar Post Code: KY15 5RR	Marital Status: Single Telephone No(s): 07546720244
Present/Past Occupation: Unemployed	Religion and/or Chaplaincy requirement:	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	Review Date	Patient Informed of Status	Clinical Risk: Yes ☒ No ☐ If yes; Specify Main Risk	Does the Adults with Incapacity Act Apply: Yes ☐ No ☒
Informal		By: Date:	Since admission expressing paranoid delusions regarding mother 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 Leona Gratton	Home Address: Unknown – wants no details documented Post Code:	Telephone No: 07762602112 Relationship: Mother
(2) Full Name: Mr Gary Gratton	Home address 57 Orchard Brae Manchester Post Code:	Telephone No: 07762602112 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 Gratton ..... Unit/CHI No: F5153833/1703751191 .....

Diagnosis

Relevant Medical Condition:	Medication Concordance:
Schizophrenia B.P.D. Eczema Asthma	

Community Service Involvement

	Name/Address	Tel No's
LMHT/Community Team COT TEAM	Dawn Stanley c/o Haldane House	01383 432725
General Practitioner	Dr Garmany Inverkeithing Medical Practice	01383 413234
Social Worker		
Community Psychiatric Nurse		
District Nurse		
Care Programme Approach Co-ordinator		
Home Care Manager		
Chaplain		
Other	Glasgow Benefits Centre, Baird St, Glasgow, G90 8BJ	
Other involvement Richmond	Dave Chaplin	
ARK	Annie Gibbs	01592 782109

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:	JC 4965 64 A	
Advanced Statement held at/with	Dunino Ward with Dr Johnson 14.09.12	

Nursing Observations

Temperature	Pulse	Blood Pressure
36.7	74	136/72

Signature of Person Completing this Form: Date: 06.01.12

updated 21/9/12

Mental Health Directorate

ADMISSION INFORMATION SHEET [A1-1]

NHS

Initial admission to Ward/Department Dunino	Community Service/Hospital: Stratheden	Admission to Hospital: Date: 06.01.12 Time: 1415
Consultant: Dr Dasgupta	Named Nurse/Case Manager: Angela Barbieri	Unit No/CHI No: F5153833/1703751191
		Care Programme Approach No:

Personal Information

FULL NAME: Mr / Mrs / Ms / Miss / Master Mr Leon Gratton	Where appropriate, likes to be known as: Leon	Previous or Maiden Name(s): n/a
	Date of Birth: 17.03.75 Gender: Male	Place of Birth: Manchester
Home Address: 85 Spittalfield Road Kirkcaldy Post Code: KY11 1DZ	Current Address: c/o Dunino Ward Stratheden Hospital Cupar Post Code: KY15 5RR	Marital Status: Single Telephone No(s): 07546720244
Present/Past Occupation: Unemployed	Religion and/or Chaplaincy requirement:	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	Review Date	Patient Informed of Status	Clinical Risk	Adults with Incapacity Act
Informal		By: Date:	Yes ☒ No ☐ If yes; Specify Main Risk Since admission expressing paranoid delusions regarding mother Refer to Care Plan No:	Does the Adults with Incapacity Act Apply: Yes ☐ No ☒ Is there an Identified Relapse Signature? Yes ☐ No ☐ If Yes; Refer to Care Plan No:

Main Carer/Partner/Relatives/Named Person Information etc

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(2) Full Name: Mr Gary Gratton	Home address 57 Orchard Brae Manchester Post Code:	Telephone No: 07762602112 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 Gratton ..... Unit/CHI No: F5153833/1703751191 .....

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Other involvement Richmond	Dave Chaplin	
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	Where appropriate - Name/Address	Tel No's
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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
36.7	74	136/72

Signature of Person Completing this Form: Date: 06.01.12

MEDICAL – IN CONFIDENCE

ADMISSION DETA

UNIT/CASE REF NO. 1 1 7 0 3 7 5 1 1 9 1 1

Surname GRATTON

Forename LEON

Title MR Initials

Previous Names —

Marital Status 8

1 Never Married
2 Married (includes separated)
3 Widowed
8 Other (includes divorced)
9 Not known

Date of Birth 17/3/75

Address 95 SLATTERFIELD ROAD
INVERKEITHING

Post Code KY11 1DZ

Have you been resident in the UK for the past 12 months? Y/N Y

Religion NONE

Occupation UNEMPLOYED

Next of Kin (relationship) MOTHER

Name MRS WONA GRATTON

Address UNKNOWN

Tel No 07762602112

Named Person (relationship)

Name

Address

Tel No

Emergency Contact (relationship)

Name

Address

Tel No

G.P.'s Name DR GALLWAY

G.P.'s Address INVERKEITHING MEDICAL PRACTICE

Tel No 01383 413 234

ETHNIC GROU

1A White Scotti
1B White Other
1C White Irish
1D Any other W
2A Any mixed b
3A Indian
3B Pakistani
3C Bangladeshi
3D Chinese
3E Any other As
4A Caribbean
4B African
4C Any other Bl
5A Any other Et
98 Refused/Not
99 Not Kn

PATIENT CATE

2 Paying
3 NHS
4 Overseas visi
5 Overseas visi
8 Other (includi

Admitting Ward DUNINO

Date of Admission 06/01/12 Time 1410

CONSULTANT

Specialty GI

G1 General Psychiatry
G3 Forensic Psychiatry
G4 Psychiatry of Old Age
G5 Learning Disability
G6 Psychotherapy
G2 Child & Adolescent Psychiatry
G21 Child Psychiatry
G22 Adolescent Psychiatry

Admission precipitated by self injury/poisoning? Y/N

Previous Psychiatric In-patient Care? Y/N Y

If yes, state Hospital name of Previous Admission/s
QUEEN MARGARET HOSP. DNE

Status on Admission 1

1 Informal
2 Informal (respite)
3 Formal

If Formal state:

Detention Order

Start: Date ... / ... / ... Time ... hours

End: Date ... / ... / ... Time ... hours

Emergency Admission Y/N N

Next of Kin/Named person to be Notified Y/N N

Advance Statement Y/N N

ADMISSION M

12 Patient admi
Out-patients
are a[illegible]able
18 Planned trar
19 Routine adm
21 Patient delay
22 Hospital day
arranging ap
equipment e
31 Patient Injur
38 Other Emerg
39 Emergency

The following apply

10 Routine Adn
20 Urgent admi
30 Emergency

TOP FLIMSY COPY TO BE RETAINED BY WARD
BOTTOM HARD COPY TO BE SENT TO MEDICAL RECORDS

NHS
Fife

FORM

CHI NO |__|__|__|__|__|__|__|__|__|__|

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on same day or following day as attendance at
for medical reasons because suitable resources

n – type not known
domestic, legal or other practical reasons)
admin. or clinical reasons, e.g.
riate facilities, for tests to be carried out specialist

elf inflicted (Injury or Poisoning)
/ Admission (inc. Emergency Transfers)
ssion – type not known

s should only be used if none of the above

on – no additional detail added
n, no additional detail added
ission – no additional detail added

|5|7|

ADMISSION REASON

51 Diagnostic
52 Therapeutic/Clinical Crisis
53 Self inflicted injury
54 Poisoning
55 Accidental injury
56 Other injury
57 Rehabilitation
58 Other type of psychiatric admission
5A Admission after extended pass
5B Respite/Holiday care
5C Learning Disability

|3|

ADMISSION REFERRAL SOURCE

1 Mental Health Out-patients
3 Direct Transfer from other Psychiatric In-patient Care ***(if this code is used the admission transfer from code should be 4D or 4E / 5D or 5E)***
4 Referral from Non-Psychiatric In-patient Clinical Ward
6 Prison/Penal establishment (including Police Station)
7 Judicial (Court)
8 Local Authority/Voluntary Agency
A Community Mental Health Services
B Self Referral
C Domiciliary Visit
D GP
E Community Care Order
F A & E Department (not admitted to an A & E Ward)
G Crisis Service

|4|D|

ADMISSION/TRANSFER FROM

11 Private Residence – living alone
12 Private Residence – living with relatives/friends
14 Private Residence – (supported)
25 Care Home
31 Holiday Accommodation
32 Student Accommodation
33 Legal Establishment, including Prison
34 No fixed abode
41 Accident & Emergency within same Health Board
43 Medical Ward within same Health Board
4B Geriatrics (except for patient on pass) within same NHS Boa
4D Psychiatric (except for patient on pass) within same NHS Brd
4E Psychiatric (patient on pass) within same NHS Board
4G Learning Disability within same NHS Board
51 Accident & Emergency from another NHS Board
53 Medical Ward from another NHS Board
5B Geriatrics (except for patient on pass) from another NHS Brd
5D Psychiatric (except for patient on pass) from another NHSoard
5E Psychiatric (patient on pass) from another NHS Board
5G Learning Disability from another Health Board

The following codes should only be used if none of the ave apply

10 Private Residence – no additional details added
20 Place of Residence – Institution – no additional details