NAME	Continuation Sheet No.	Unit No.

F515383

GRATTON, LEON
85 Spittalfield Rd
Inverkeithing
KY11 1DZ

CHI: 170375119
D.O.B. 17/03/197

21/9/09 Voices – sporadic
Heads hurt "migraine" – bil
for hours, bright lights, sits in dc
Dark, eyes hurt + ×1/2 per week
after lecture
weeks ×1/week – worse +
outside + loud, sounds as if
severe deafness = linked –
shouts behind at times,
A I just sat on with it? – now
depressed
Been busy – has a school
c/o low mood –
Hx called = panics by phone
mood in mood –
Trial of citalopram 20g daily

MS820

18/8/10 DNA

Surname GRATTON	Unit No.
First Names LEON	Date seen or Admitted 25/04/08
Maiden Surname	Seen at Ward 2
Address	Seen by [illegible]
	Consultant in Charge [illegible]
	Family Dr.
	Referred by

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

PRESENTING COMPLAINT **DETAINED** YES/NO

- Referred by CMHT.
- Phoned them today ~~about~~ that he was going to take an overdose of valium (Diazepam) unknown quantity + Paracetmol + Slimming tablets with Bleach.
- Denies taking anything currently.

HISTORY OF PRESENTING COMPLAINT

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

PAST PSYCHIATRIC HISTORY

- Paranoid Schizophrenia
- Borderline Personality Disorder.

FAMILY PSYCHIATRIC HISTORY

PAST MEDICAL HISTORY

- Eczema
- Asthma.

CURRENT MEDICATION

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

- Clopixol 100mg / weekly.

NAME	Continuation Sheet No.	Unit No.

PERSONAL HISTORY

Born in Manchester. Moved to Edinburgh since he was 2.
Known to MH Services.

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

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

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

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

Little insight to his circumstances.

SUMMARY
(including formulation, diagnosis and differential diagnoses)

- 33 year old gentleman with Hx of Paranoid Schizophr becoming unwell recently.
- Thinking to take an overdose as he is tired of his circumstances also thinking to kill his neighbours because they are bothering him.

TREATMENT PLAN
(including observation status)

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

Name of Admitting Doctor

Signature

NAME Leon Cratton	Continuation Sheet No.	Unit No.

28/4/18 ur Dr Cavanagh Hx of schizophrenia 0383 412328

- Admitted ↑ hearing voices / suicidal thoughts.
- Social circumstances ↓ mum possibly abused grandson - has been stressed
- Insomnia. Worries during the day.
- ↑ depot ≈ 2/52 ago : feels it has helped. Feels calmer (Thursday).
- Voices have improved since admission.

(P) 1) 2/7 more days in ward to review mental state
2) Passes : 4hrs. if need to (H) to get clothes.

Dr Keaberry (ST2)

29/4/18 ur Dr

ATS Doctor - Wanting to go (H)

(1) Voices - Remains. Has heard voices on a daily basis since he was 21yr. Some parts of day - voices recede particularly when distracted
Numerous voices : talking TO him → saying derogatory / scandalous things to him about him. All male voices
Voices still present but not as distressed by comments

(2) Suicidal ideation - Has thoughts every so often, but does not plan or think that he will act on his thoughts.
Thoughts minimal today. His son stops him from carrying out acts of self harm.

(3) Has no homicidal ideation. If neighbour disturbs him - he will call police

MSE (A) Casually dressed. Modrately kempt
(B) Appropriate. Dslute. Good eye contact
M - O + S - (N)
Mood - No ψ motor retardation / No obs (N) movements
Thoughts - as above. wants to go home. Feels better. Finds ward cold
Percep - as above
Suicide / Homicide - as above.
Insight - Feels better. Aware feels better / less distressed.

(P) 1) D/C today to Richmond Fri / Mon / Tue / Wed / Thu / Sat / Sun
2) UFEDT 3x / week 3) Dr Cavanagh 4) Carers clinic (depot) ←

MS878

8/6/18

DEAR DOCTOR,

EON GRATTON, 17/3/75

THANK YOU FOR ACCEPTING THE TRANSFER OF THIS 33 YR OLD MAN KNOWN TO DR CAVENDISH WITH HX OF SCHIZOPHRENIA.

HE TOOK OVERDOSE OF ~ 16 PARACETAMOL 500mg TABLETS @ 1130 AM TODAY ON 8/6/18. NOW MEDICALLY FIT FROM WD-8. PATIENT HAS CONTINUING SUICIDAL IDEATION AT PRESENT + LOW MOOD. PAST OD's / OSH.

DUE TO ↑ RISK I FELT HE WOULD BENEFIT FROM CRISIS ADMISSION — UNFORTUNATELY NO BEDS IN WD 2 QMH (CHASE).

TAKES CLOPIXOL DEPOT ON TUESDAYS — ? DOSE
— NO NOTES LOCATED AND NFOT UNAVAILABLE TO DISCUSS DOSE — WOULD NEED TO CONTACT TODAY MANE.

THANK YOU FOR YOUR HELP.

(DR CHRIS OLLEY) SHO (2293)

NAME LEON GRATTON	Continuation Sheet No.	Unit No.

3/6/8
5.30pm

F5153833 DOB = 17/3/75 85 SPOONER RD INVERCARGILL — DR GERMONY FRIARY CT, INVERCARGILL MEDICAL CENTRE

SHO ON CALL FOR PSYCHIATRY — REFERRAL FROM ED & CMHT.

PC: PARACETAMOL OVERDOSE

* UNFORTUNATELY NOTES NOT LOCATED

— 33YR OLD MAN
— KNOWN TO DR GERMONY
— HX OF SCHIZOPHRENIA.
— WFCOT NOT CONFIRMED WHEN LAST SEEN MEETING IN MAY 08.

HPC:

— PARACETAMOL OVERDOSE @ ~ 11.30AM ON 8/6/8 OF ~ 16 TABLETS OF PARACETAMOL.

— 'LONELY, DEPRESSED, SUICIDAL' — 'LONG TIME'
— LOW YESTERDAY — SUICIDAL THOUGHTS BUT 'DISMISSED THEM'
— TODAY
— YEARS.
— VARIES.
— LOW FOR ~1YR.

— LISTENING TO MUSIC — ↑ FELT 'BLOCK' 'TIRED'
— TOOK TABLETS — BOUGHT 16 PARACETAMOLS FROM SHOP
— WENT HOME, DRANK, TOOK TABLETS — ↑ PANICKED
← PHONE SAMARITANS / ALCOHOL ~~DRUGS~~
— FATHER PHONED ~~THEN~~ BURGLAR — PANIC BUTTON UNDER DESK 'D DONE — ↓ OFF.
— 'HOPING TO DIE', THOUGHT IT WOULD WORK.
← ° PLAN ° SUICIDAL NOTE ° PLANS IN PLACE IF DIED.
— 'STILL WANTS TO DIE' ° ALCOHOL/DRUGS TODAY/YESTERDAY
— CONTINUES TO HAVE SUICIDAL IDEATION — ? SPECIFIC IDEATION/PLAN

— MOOD = 'DEPRESSED' 'SUICIDAL' — YES — MOOD LIFTED AS DAY GOES ON BUT VARIES
— SLEEP — 'UP + DOWN' — OK RECENTLY. — NOT GOOD LAST NIGHT — CAN'T REMEMBER LIKE LAST FEW GOOD
— SPENDS TIME READING/WRITING — ENJOYS — 2 DOGS.
— SELF CARE GOOD, APPEARS GOOD; WEIGHT LOST — 25KG ↓ IN 5MTHS

— ENDURING VOICES — V. DISTRESSED AT PRESENT 47 3997 2293 8191 8194
— °FRIENDS / FAMILY TO SUPPORT — GRVS SUPPORT FROM RICHMOND FELLOWSHIP
— ? DOESN'T CARE ABOUT FUTURE ('? DUPE')
— THINKS 'HE'S A SCUMBAG' — ↓ SELF WORTH.
— DENIES PSYCHOSIS / DEPRESSION °PROBLEMS WITH SLEEP
— °HALLUCINATIONS — DENIES PSYCHOTIC SYMPTOMS

'DST PSYCH Hx.

— POST DIAGNOSIS TO MDT IN POST.
— LAST ADMISSION TO WARD 2 — D/C 6/2/8
— SCHIZOPHRENIA — IN POST FROM VOICES / NON COMPLIANCE — MOOD DELUSIONAL COMMENTS
TRIED 18 MEDICATIONS — OF PSYCHOSIS + VISUAL
— WEIGHT — 38st LOST WK.
— MISSED LAST OF DEPT 3 WKS PRO WITH DR CONSULTANT — (MISSED DUE)
— OVERDOSES IN POST — XMAS 08 — LAST TIME.
— ~~HOME~~ ATTEMPTS HANGING — 3 YRS AGO

MH

SCHIZOPHRENIA

MEDS

— CLOPIXOL DEPOT IM — WKLY — LAST ON TUE (DUE ON TUESDAYS) MISSED LAST WK.
— NITRAZEPAM 10mg NOCT.
— DIAZEPAM 5mg NOCT./PRN.

ALLERGY

NKDA.

→ NO SE'S
— BRIGHT — ↓ VOICES.

↓

— ANXIETY — AGORAPHOBIA.
— MUM (? DEC) — CONFIRMED CONCIOUSNESS IN EDINBURGH IN FLATS — NOT IN CONTACT FOR FEW WKS.
— DAD (56) — BUILDING SITE MANAGER — SEES X1/YR — SPOKE X2/LA — LIVES IN MONTROSE
— SISTER X2 (23 + 27) — NOT IN CONTACT FOR YRS.
— °PARTNER — SINGLE.
— SON (9) — NOT IN CONTACT WITH DAD / MOTHER.

NAME LEON GRATTON.	Continuation Sheet No.	Unit No.

PERSONAL HX-

- BORN IN MANCHESTER — COMPLICATIONS.
- BROUGHT UP WITH BOTH PARENTS, TOGETHER
- LIVED WITH PARENTS — @ 3 — SOCIAL SERVICES — HE LIVED WITH MUM — DOES OFF ON MUM HER — SOF COULD HAVE MORE.
- 1° SCHOOL IN W. HAMS 2° — TRUANT — LEFT SCHOOL @ 16 — 15 GRADE
- WORKED AS SLASHER IN EDINBURGH — 6 MTHS — CANNABIS, LSD, GRUF
- STOPPED DRUGS 2 YRS AGO — STARTED FROM SCRATCH IN FISH, POTATO PICKING
- PSYCH HOSPITAL.

SH — LIVES ALONE IN COUNCIL HOUSE IN NEWHAVEN
- UNEMPLOYED — LOST WORKS AT DSDA STARTED 6 YRS AGO.
- DLA + INCOME SUPPORT.
- SMOKES 20/DAY

ALCOHOL — NON DRINKER — ALCOHOL FITS @ XMAS 07, FEB 06
- ? ALCOHOL OFF — 3 YRS AGO

DRUGS — NIL RECENT
- LOST HERO 4 YRS
- CANNABIS — OCCASIONAL JOINT
  TRIES COCAINE, AMPHETAMINE, LSD.

FORENSIC HX.

- ASSAULT — FINES
- SHOPLIFTING — FINES.
- NO PRISON

MSE

- A+B — CASUAL DRINKER CANNABIS MON, GOOD EC + RELATIONS REPORT ° BEHAVIOUR MANAGEMENT. ↓ EXPRESSION IN FACE.
- S + F — MONOTONE, ⓦ r, c, ↓ VOL. ° FTD.
- M 'depressed' 'suicidal' ⓞ low mood ↓ reactivity
  (... 1.0) 'lonely' 'depressed' on

(P) - denies, risk aboard, not open ready to hallucinate

(C) - grossly intact - oriented to T, P, P

(I) - good insight - realises feels low in mood + psychotic symptoms
- willing to accept help + take meds
- willing for admission

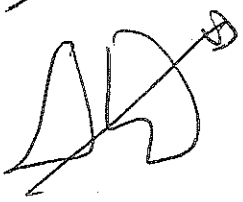
(C) - suicidal attempt - OD today - continues to have suicidal ideation ? specify suicidal ideation + plans.
- denies homicidal ideation/plan

MP - 33 yr old man known to WD2 / DR CROSSLEY
- Hx of schizophrenia
- overdose of ~16 paracetamol 500mg tabs today
- low mood, depressive symptoms
- confirmed to have 'succeeded' - post attempts inc hanging
- lives alone, close family / friends support.
- due to ↑ risk, post OSH + schizophrenia. for ↓ NEEDS CRISIS ADMISSION.

PLAN
- information to MDT reds at WD2, QMH.
- transfer from WD 8 — o woodbank, kirkdale
- informal admission
- general obs.
- kardex.
- o/e ✓ bloods ✓ (coming out in WD 8 bc meds)
- meds same medication fit for D/C — obs stable
- depot due on [illegible] — missed last one.
? none — need to check with [illegible] Dr

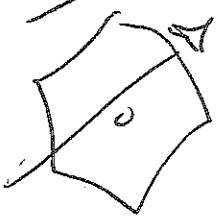
— UNFAMILIAR ABLE TO LOCATE HIS NOTES.
— VERIFY MEDICATION WITH HIS GP MONDAY
— PRN STOMA.
— ASK MEDICAL STAFF TO R/V IF KNOW FOR D/C
— NOTE FBC – WCC = 13.8 – ? DUE TO OVERDOSE – MEDICS SUGGEST CO AMOXICLAV IF REMAINS ↑WCC + SYMPTOMATIC.
— NO SIGNS OF INFECTION / OBS STABLE NO PYREXIA
— MEDICS HAPPY FOR D/C.

O/E:



RR = 15
O_2 SATS = 100% ON RA

CVS
HS I+II +0
0 MURMURS
BP = 125/70
HR = 75 REG.



RS
– CLEAR BILAT

(COLOSTOMY)
SITU/22/7

DAD 0161 776 1420

08.06.08 21[30]

Ryz mclean (@ Whytemans Brae)
(on-call psychiatry)

Bloods (on SCI) from 8/6/8:

Hb 15.7		PT 11
WCC 13.8 ↑		APTT 34
Neut 10.13 ↑		Fib 3.4
Plt 244		

Remainder of bloods not on SCI yet.

Up to date info since transfer:
Pt "fine"
Regarding suicidality "no point in here, can't do it in here". If weren't in WBH, "don't know" what he'd do.
Denies active plans.

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

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

(P) R/V by Dr. Smith
ECG requested
Pls. chase remainder of bloods.
Will need confirmation of meds as requested by QMH SHO.
?Location of notes

pmcleer (fyz)

9/6/18 Medical Review

~~Admitted yesterday~~
~~Long standing~~ Δ of schizophrenia.
— regular admissions to QMH
2 this year. F63 'or' for 2/52 post OD
and readmitted "4 weeks ago" for 2/7

Usual support:
OPA Dr Carragh 4/52 (missed last)
CPN 1-2x weekly. Dipt Tuesday
Richmond fellowship 5x weekly

Last 4/52 law word. Nil psychotic
Tried to press charges against mother for abuse as child and concern over safety of his 4yo son (lives with ex partner, mother has access, he does not)
No delusional Sx of depression sleep/app/energy OK

Imp No clear e/o depression
Paranoid Schizophrenia. Recent stress with mother
Ongoing suicidal ideation, no intent/plans
Agrees to stay informally. NAT detainable today
Await Outpatient bed → transfer JJ Smith

NAME LEON GRATTON	Continuation Sheet No. 17.3.75	Unit No.

11/6/18

Admitted 4-5/7 ago w O/D of paracetomol
- 2/7 prior heard that charges against mum for sexual abuse against him & son were drops. Thoughts of this in head and thoughts of previous rape: Felt had enough: Didn't want to live
→ Took paracetomol, then phoned Maidone / Dad. His dad phoned SAS - A+E.

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

Mood - low for a long time. Energy olc. Appetite olc Sleeping well
Enjoys company of people. Feels is lonely in community

(P) 1) Observe one next day or two
2) RV R Cavenagh Friday → new to dlc?

Greenberry CST

12/6/18

- Nursing Report - laughing lonely/ animated. Talking of mania
- Asked about mania - felt kicks @ school mentioned 'malicious'. Felt last admission had a cut on thought
- Hearing echos - an 'oooo' noise. Not heard screaming
- Feels safe on ward
- Sleeping better

(P) 1) ~~Encouraged~~ ~~Encouraged~~. Tablets in view of ↑ ~~encouraged~~.
2) DIC in dept. clinic. Eye clinic done.

Greenberry CST

16/6/18 Occasional

Sleeps OK.

Has been observed having
wider alone - demon
play. " what I how is
screams - He's like some
is getting attached "
Always a female voice - in
the distance - couple of words -
Has stopped the going before.
Smacked still happening.

18/6/08 Remains settled, interacts
well. Spending time in bed. Assessed
by Portsmouth Fellowship for support
do home. Concerned about some
scripts - no observed response to
[illegible].
No evidence of recent [illegible].
Improving response to discharge [illegible]

NAME Leer Gratton	Continuation Sheet No.	Unit No.

23/6/18

Had w/e pass - difficult: auditory hallucinations
- "out side & in my head" - laughter.
Took extra fluperbirsol tablets on Saturday
- purpose of tablets - "stop the voices" → worked
Phoned ward / Samantha over w/e - "someone to talk to"
During the day - slept. "As soon as I get back to that home..."
Thinking - "A couple of hours, I just about cracked up."
Suicidal ideation - "Nowhere to go & do it"

(P) 1) ↑ depot
2) 1 on pass to Friday
3) Kadex for depot clinic

Ereabem (STR)

24/6/18

UAEs - Na - 140 / K - 3.7 / U - 5.1 / Creat - 100.
On pass till Friday

Ereabem (STR)

27/6/18

Back from pass. Felt passes went well - felt well.
Didn't attend depot clinic yesterday - depot today
Asking for d/c.
- ? with Richmond went to hearing support centre to look @ creative writing - seems keen.
- No current auditory hallucinations ° Paranoia - denying.
- No thought of suicide / no plans / no attempted or temptation to O/D. Appears bright/no responsivity / ° FTD.

(P) 1) D/C w/ med (daily dispensing)
2) Depot.
3) UPCOT / Richmond F/U.

MS878

Ereabem (STR)

Forename: LEON	Address: 85 SPITTALFIELD RD	DOB: 19/3/75
Surname: GRATTON	INVERNESS IV1 1NQ	CHI No / Hospital No: F315 3483

Medicines on Discharge

Medicine Form & Strength	Dose	Directions for Administration	Continuous/ Course Length	Quantity Supplied
NITRAZEPAM	10mg	ORAL /NOCTE	Cont	1/7 - 28 tabs
FLUPENTIXOL DECANOATE	150mg	WEEKLY	PRESCRIBED	

Medication currently prescribed by Day Hospital: Yes ☐ No ☑

Dispense in Compliance Aid Yes ☐ No ☑
Type of compliance aid before admission: .....

Significant Changes to Medication from the Point of Admission

Medicine	Stopped/Started/ Changed	Details of Change and Reasons

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

Adverse Reactions/Allergies: Yes ☐ No ☑ Detail:

Comments:

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

Name (in CAPS): [illegible]

Contact No. for enquiries: 2298

Designation: Consultant/Registrar ☐ SHO ☑ JHO ☐ Other ☐ _____

Clinically Checked by Pharmacist: _____
Dispensed: _____
Check: _____
Date: _____

NHS Fife

DATE OF ADMISSION: 8 / 6 / 2008
DATE OF DISCHARGE: 23 / 6 / 2008

IMMEDIATE DISCHARGE & PRESCRIPTION FORM

Hospital Site: QUH

(Please use BLOCK CAPS when completing this form)

Re: Mr/Mrs/Miss/Ms	DOB: 14/12/75	TO: GP Forename: DR
Forename: LEON	Surname: GRATTON	GP Surname: CUPERNALL
Address: 53 SPITALFIELDS		GP Address: DUNFERMLINE MH
DUNFERMLINE		
Postcode:		GP Postcode:
CHI No:	Hosp ID No: F513313	Community Pharmacy:

This patient was admitted to hospital under the care of:

Consultants Name: DR CUPERNALL	Specialty: PSYCHIATRY
Discharged from Ward: 3	Reason for Admission/presenting complaint: ASSAULT FOLLOWING ARREST FOR DRUNK & DISORDERLY

Mode of Admission: Elective ☐ Emergency ☐ Transfer ☑ (from A&E) **Source of admission:** GP ☐ Self ☐ Out of Hours ☐ Other: ☑ POLICE

Principal Diagnosis: SCHIZOPHRENIA **Legal Status:** INFORMAL

Other Conditions:

1
2
3
4
5

Significant Operations/Procedures: Yes ☐ No ☑

1. Date:
2. Date:

Relevant Investigations: Yes ☐ No ☑ Comments:

Complications: Yes ☐ No ☑ Comments:

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

Follow-up Arrangements

WFC OT
DR CUPERNALL'S OPD.

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

DATE OF ADMISSION: 01 / 02 / 08
DATE OF DISCHARGE: 06 / 02 / 08

IMMEDIATE DISCHARGE & PRESCRIPTION FORM

NHS Fife

Hospital Site: QMH

(Please use BLOCK CAPS when completing this form)

Re: Mr/Mrs/Miss/Ms	DOB: 17/03/75	TO: GP Forename: Dr
Forename: LEON	Surname: STRATTON	GP Surname: GP SURGERY
Address: 20 SMITH FIELD		GP Address: WOODSIDE MEDICAL
WINDYGATES		CENTRE, 5 FERRY ROAD
Postcode: KY11 1DZ		GP Postcode: KY11 1DZ
CHI No: 170375 0119	Hosp ID No:	Community Pharmacy:

This patient was admitted to hospital under the care of:

Consultants Name: CANAVAN	Specialty: PSYCHIATRY
Discharged from Ward: 2	Reason for Admission/presenting complaint: PSYCHOLOGICAL CONT

Mode of Admission: Elective ☑ Emergency ☐ Transfer ☐

Source of admission: GP ☐ Self ☐ Out of Hours ☐ Other:

Principal Diagnosis: SCHIZOPHRENIA

Legal Status: INFORMAL

Other Conditions:

1. SCHIZOTYPAL PERSONALITY DISORDER
2.
3.
4.
5.

Significant Operations/Procedures: Yes ☐ No ☑

1. Date:
2. Date:

Relevant Investigations: Yes ☐ No ☑ Comments:

Complications: Yes ☐ No ☑ Comments:

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

Follow-up Arrangements

WFCOT
OPD
Dysthymia Therapy

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

Forename:	Address:	DOB:
Surname:		CHI No / Hospital No:

Medicines on Discharge

Medicine Form & Strength	Dose	Directions for Administration	Continuous/ Course Length	Quantity Supplied

Medication currently prescribed by Day Hospital: Yes ☐ No ☐

Dispense in Compliance Aid Yes ☐ No ☐
Type of compliance aid before admission: .....

Significant Changes to Medication from the Point of Admission

Medicine	Stopped/Started/ Changed	Details of Change and Reasons

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

Adverse Reactions/Allergies: Yes ☐ No ☐ Detail:

Comments:

Signature: _____ Date: _____

Name (in CAPS): _____

Contact No. for enquiries: _____

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

Clinically Checked by Pharmacist: _____

Dispensed: _____

Check: _____

Date: _____

Forename:	Address:	DOB:
Surname:		CHI No / Hospital No:

Medicines on Discharge

Medicine Form & Strength	Dose	Directions for Administration	Continuous/ Course Length	Quantity Supplied

Medication currently prescribed by Day Hospital: Yes ☐ No ☐

Dispense in Compliance Aid Yes ☐ No ☐
Type of compliance aid before admission: .....

Significant Changes to Medication from the Point of Admission

Medicine	Stopped/Started/ Changed	Details of Change and Reasons

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

Adverse Reactions/Allergies: Yes ☐ No ☐ Detail:

Comments:

Signature: _____ Date: _____

Name (in CAPS): _____

Contact No. for enquiries: _____

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

Clinically Checked by Pharmacist: _____
Dispensed: _____
Check: _____
Date: _____

NHS Fife

DATE OF ADMISSION: / / **DATE OF DISCHARGE:** / /

IMMEDIATE DISCHARGE & PRESCRIPTION FORM

Hospital Site:

(Please use BLOCK CAPS when completing this form)

Re: Mr/Mrs/Miss/Ms	DOB:	TO: GP Forename:
Forename:	Surname:	GP Surname:
Address:		GP Address:
Postcode:		GP Postcode:
CHI No:	Hosp ID No:	Community Pharmacy:

This patient was admitted to hospital under the care of:

Consultants Name:	Specialty:
Discharged from Ward:	Reason for Admission/presenting complaint:

Mode of Admission: Elective ☐ Emergency ☐ Transfer ☐

Source of admission: GP ☐ Self ☐ Out of Hours ☐ Other:

Principal Diagnosis:	**Legal Status:**

Other Conditions:

1
2
3
4
5

Significant Operations/Procedures: Yes ☐ No ☐

1. Date:
2. Date:

Relevant Investigations: Yes ☐ No ☐ Comments:

Complications: Yes ☐ No ☐ Comments:

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

Follow-up Arrangements

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

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

PRESCRIPTION SHEET No.

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
18/12/08																		1	CH							L DUE 28.12.08
23/12/8																		1	KR							R DUE 30-12-8
30/12/08																		(+)	ME							cf 6.01.09
31/12/8																		1	DS							(L) 7-1-9
8/01/09																		(+)	ME							cf 13.01.09
13/1/9																		1	KR							(R) DUE 20/1/9
20/1/9																		1	KR							(L) DUE 27/1/9.
27/1/9																		1	KR							(R) DUE 3-2-9
3/2/9																		1	KR							(L) DUE 10-2-9
10/2/09																		1	CH							(R) 14.2.09
17/2/09																		1	[illegible]							L due 24.2.09
24/2/09																		1	AB							(R) due 03.03.09
3/3/09																		(1)	[illegible]							CT 5.3.09
5/3/9																		(Ø)	DS							clp 10-3-9

NAME: LEON GRATTON UNIT No: F5L538833 WARD: CARNEGIE CLINIC

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

PRESCRIPTION SHEET No.

(A) KEY
(A) 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
19/3/09																		1	CH							L 14·309
17/3/9																		1	JS							(R) 24-3-9
24/3/09																		1	TS							(L) 31/3/09
31/3/09																		1	TS							R 7/4/09
7/4/09																		1	AK							L dw 14·4·09
14/4/09																		(1)	CH							CP 16·4·09
16/4/9																		Ø	NJ							CP 21-4-9
21/4/09																		1	CH							R 28·4·09
22/4/9																		1	JS							(L) 5-5-9
5/5/9																		1	NJ							R 12-5-9
12/5/09																		(1)	CH							CP 14·5·09
14/5/9																		Ø	NJ							CP 19-5-9
19/5/09																		1	AK							(L) dw 26.5.09.
26/5/09																		(1)	MC							CP 28.5.09

NAME: LEON CRATTON UNIT No: FS153837 WARD:

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

PRESCRIPTION SHEET No.

KEY
(A) DRUG REFUSED
(Ø) 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
7/2/8																		1	DB							(R) 14/2/8
15/2/08																		1	TS						Due visit	(R) 15/2/08
22/2/08																		1	TS						being visit	(L) due 28/2/08
29/2/08																		1	TS						H/N	(R) due 6/3/08
8/3/08																		1	TS						H/N	(L) 15/3/08
14/3/08																		1	TS							(R) 21/3/08
21/3/08																		1	TS							(L) due 28/3/08
28/3/08																		1	TS							(R) due 3/4/08
3/4/08																		1	CH							(L) due 10/4/08
6/4/08																		1	TS							R 23/4/08
25/4/08																		1	TS							(L) 25/4/08
6/5/8																		Ø	KR							C/F → 8/5/8.
7/5/08																		1	TS							due 14/5/08
15/5/08																		1	TS							due 22/5/08

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

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

KEY
Ⓐ DRUG REFUSED
Ⓐ̸ PATIENT ABSENT

MEDICINE RECORDING SHEET

Date	REGULAR PRESCRIPTIONS 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
23/5/08																		1	AC							R due 29.5.08
27/5/08																		1	TS							Ⓒ due 3/6/08
3/6/8																		Ⓐ	KR							C/F → 5/6/8

NAME: LEON GRATTON UNIT No: .... WARD: SOT

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

PRESCRIPTION SHEET No.

(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
3/7/8																		(A)	KR							C/F 7 8/7/8
8/7/08																		(1)	AK							(L) 17.7.08
22/7/08																		1	CH							(L) 29.7.08.
5/8/8																		(A)	MS							cl 7.8.8
11/8/08																		(1)	AK							CF 12.808
8/8/8																		1	DS							14-8-8
14/8/08																		(A)	AK							CF 19.8.08
19/8/08																		(A)	AK							CF 21-808
22/8/08																		1	TS							
28/8/8																		(A)	KR							C/F 7 4/9/8
4/9/08																		1	TS							due 11/9/08
11/9/08																		1	TS							(R side) 17/9/08 due
20/9/08																		1	TS							27/9/08 due (L)
26/9/08																		1	TS							(R) due 2/10/08

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

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

PRESCRIPTION SHEET No.

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
2/10/08																		1	TS							(L) due 9/10/08
9/10/08																		1	AZ							L due 16-10-08
16/10/8																		1	DS							(C) 23-10-8
23/10/08																		1	TS							(R) due 30/10/08
30/10/8																		(A)	DJ							CH 4/11/8 letter sent
4/11/08																		(A)	CH							CF 6/11/08
6/11/08																		(A)	AS							CF 11-11-08
7/11/08																		1	TS							15/11/08 (R)
14/11/08																		1	TS							(C) 21/11/08
20/11/8																		1	DS							(R) 27/11/8
27/11/8																		1	DJ							(C) 5-12-8
4/12/08																		(A)	MK							CF 9.12.08
9/12/08.																		1	CH							(R) 16-12-08
16/12/08																		(A)	CH							CF 18-12-08

NAME: Leon Gratton UNIT No: 5153833 WARD: Carnegie Clinic

PRESCRIPTION SHEET (USE BLOCK LETTERS)

Sheet No. 2 of 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												
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	25/4/18			SYMPTOMATIC RELIEF POLICY	AS PER PROTOCOL				
S	25/4/18			LORAZEPAM	2mg	ORAL	Agitation	Max 8 mg In 24 hrs	
T	25/4/18			LORAZEPAM	2mg	IM	Agitation	Max 8 mg In 24 hrs	
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

NAME OF PATIENT EMMA GRATTON | AGE 23 | DATE OF BIRTH 17/3/95 | UNIT No. | CONSULTANT Dr CAVANAGH | WARD 2

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

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

	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	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)

Sheet No. 1 of 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												
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	26/4/18			NITRAZEPAM	10mg	oral	Insomnia	small only at night	
S	26/4/18			Symptomatic relief	as per protocol				
T	26/4/18			LORAZEPAM.	2mg	oral	AGITATION	4mg in 24°	
U	26/4/18			LORAZEPAM	2mg	IM	AGITATION	4mg in 24°	
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
26/4/18	DIAZEPAM	5mg	ORAL	18.30		LR SH	18.35
27/4/18	GAVISCON	10ml	oral	1400			
28/4/18	DIAZEPAM	5mg	ORAL			PS SH	20.35

NAME OF PATIENT [illegible] | AGE | DATE OF BIRTH | UNIT No. | CONSULTANT DR C MANAGHAN | WARD 2

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

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

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	8/6/8			NITRAZEPAM	10mg	ORAL				✓		
B	13/6/08			~~Zuclopenthixol~~	~~10mg~~	~~O~~						
C	13/6/08			~~Fluphenthixol decanoate~~	~~100mg~~	~~O~~	✓		✓			
~~X~~	~~13/6/08~~	ERROR		~~Fluphenthixol decanoate~~	~~4mg~~	~~O~~						
E	13/6/8			CLOTRIMAZOLE 1% cream	1 applic	Topical-penis	✓		✓			
F	~~14.06.08~~	~~23.6.08~~	~~DE~~	~~FLUPENTIXOL DIHYDROCHLORIDE~~	3mg	ORAL	✓	✓	✓	✓		
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	8/6/8			SYMPTOMATIC RELIEF AS PER PROTOCOL					
~~S~~	~~8/6/8~~	~~12.6.08~~		~~LORAZEPAM~~	~~1-2mg~~	~~ORAL~~	~~AGITATION~~	~~4mg/24hrs - 1 hrly~~	
~~T~~	~~8/6/8~~	~~12/6/8~~		~~LORAZEPAM~~	~~1-2mg~~	~~IM~~	~~AGITATION~~	~~1 hrly 4mg/24hrs~~	
U	8/6/8			LORAZEPAM	1-2mg	ORAL	AGITATION	once in 24hrs	
W	14/6/8			CHLORPROMAZINE	50mg	oral	agitation	4-6hly max 300mg/24hrs	
X	14/6/8			PROCYCLIDINE	5mg	oral	EPSE's	6-8hly max 30mg/24hrs	
Y	14/6/8			EMSURLAM	1 applic	topical	dry skin/rash	As required	
Z	27/6/8			LORAZEPAM	1-2mg	IM	AGITATION	4mg in 24hrs	

	START DATE	DISCONTINUED Date	DISCONTINUED Signature	DEPOT INJECTIONS	DOSE	FREQUENCY	PRESCRIBER'S SIGNATURE
1	8/6/8			~~CLOPIXOL (Zuclopenthixol decanoate)~~		~~WEEKLY (IM)~~	
2	~~13/6/08~~	~~23.6.08~~	~~DE~~	~~Fluphenthixol decanoate~~	~~100mg~~	~~weekly~~	
3	23.6.08			Fluphenthixol decanoate	150mg	weekly	
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
~~13/6/08~~	~~Zuclopenthixol decanoate~~		~~I.M~~	~~10.00~~			
13/6/08	Fluphenthixol decanoate	100mg	I.M	10.00		SR. JUNE	1720hrs
13.6.08	FLUPENTIXOL DIHYDROCHLORIDE	3mg	ORAL	20:00		CHG RN	2215.

NAME OF PATIENT 1 [illegible] GRATTAN | AGE 22 | DATE OF BIRTH 17/2/[illegible] | UNIT No. F[illegible]3827

CONSULTANT DR CAVANAGH / DR SHITZ

WARD WCOOBAN FHB(MR) 58

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

	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	**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)

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	01/02/08			NITRAZEPAM	10mg	ORAL				✓		
B	01/02/08	4/2/08		DIAZEPAM	10mg	ORAL			✓			
C	4/2/08			DIAZEPAM	6mg	O				✓		
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	01/02/08			SYMPTOMATIC RELIEF PROTOCOL (EXCEPT PARACETAMOL)					
S	01/02/08			LORAZEPAM	1mg	ORAL	AGITATION	MAX 4mg/24 hr	
T	01/02/08			LORAZEPAM	1mg	IM	AGITATION	MAX 2mg/24 hr	
U	01/02/08			HALOPERIDOL	5mg	ORAL	AGITATION	MAX 30mg/24 hr	
W	01/02/08			HALOPERIDOL	5mg	IM	AGITATION	MAX 15mg/24 hr	
X	2/2/18			IBUPROFEN with food	400mg	ORAL	PAIN	MAX TDS 8 hourly 4 hrly PRN	RIVEN 4/2/18
Y									
Z									

	START DATE	DISCONTINUED Date	DISCONTINUED Signature	DEPOT INJECTIONS	DOSE	FREQUENCY	PRESCRIBER'S SIGNATURE
1	01/02/08	4/2/08		FLUPENTIXOL DECANOATE	50mg	WEEKLY	
2	4/2/08			FLUPENTIXOL DECANOATE	100mg	WEEKLY	
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: LEON GRATTON | AGE | DATE OF BIRTH: 17/03/75 | UNIT No.: FS/S 3853 | CONSULTANT: Dr CAMPBELL

WARD 2

FHB(MR) 58

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

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

	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	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

PL 150

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									

Discontinued
Laudelli
P/T 10/8
New Kardex Written

	START DATE	DISCONTINUED Date	DISCONTINUED Signature	DEPOT INJECTIONS	DOSE	FREQUENCY	PRESCRIBER'S SIGNATURE
1	07/02/08			FLUPENTIXOL DECANOATE	100 mg	WEEKLY	
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 LEON GRATTON | AGE | DATE OF BIRTH 17/05/75 | UNIT No FS1538334 | CONSULTANT CANNAGH | WARD DEPT CLINIC

FHB(MR) 58

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

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

	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	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 IS CHANGED
PRESCRIPTION SHEET No.

KEY
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
22/6/08			(E)	SH	F	SE	A (E)	AM									
23/6/08	(E) F	US (E)		SH		JM		OR									
							A (E)	CR									
								AF									
24/6/8	(E)	PS	Issued with SP. A as PASS US														
		SH	meets 1:c of 10pm 24/6														
25/6/08	(E)	JH RH															
26/6/08			Pass meets US issued 1:c of 10pm 26/6														
27/6/08																	

DEPOT INJECTION

Code	Intls
3	SH

AS REQUIRED

Code	Time	Intls	Code	Time	Intls
W	1235	SH			
Kg	1700	US			
Rg	1805	SE JM			
Y	1815	SE SH			

COMMENTS ON DISCREPANCIES

(E) Refusal.

Depot Given (R) SDF Next Due 3/7/08 @ Carlaw Clinic

NAME: LEON GRATTON UNIT No: F5153833 WARD: 2

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
8/6/08							M	NF									
9/6/08							A	NF									
10/6/08							A	AM NF									
11/6/08							A	AM QHS									
12/6/08							A	AM QHS									
13/6/08							A (E)	RM QHS	~~F~~	2200	~~RM~~						
13/6/08																	
14/6/08	F	E	AN SE	(E)	SE M	F	SH PS	A (E)	PCH	E	1700						
15/6/08	E	F	PS (E)	(E)	PS SH	F	JH	A E	PCH LR								
16/6/08	E	F	SH	E	SE	F		A E	PCH LR								
17/6/08	E	F	SH (E)		SE	F	JH PS	A E	PCH LR								
18/6/08	E	F	PS SE	(E)	SE	F	LB HB	A E	PCH LR								
19/6/08	E	F	SE (E)		JH SH	Pass Meds Inclusive Friday 20/06/08 issued on 18/06/08											
20/6/08			Pass Meds Unit 23/06/08		Pass Meds Ward Stock												

Date	DEPOT INJECTION Code	Intls	AS REQUIRED Code	Time	Intls	Code	Time	Intls	COMMENTS ON DISCREPANCIES
8/6/08									
9/6/08			S	19-30	9m				S = 1mg @ 19-30
			Rg	21-40	1/2				Rg = 1mg @ 21.40
10/6/08			S	1820	SE				S-1mg at 1820
11/6/08			Rg	2205	QHS				
12/6/08									
13/6/08			Rg	0255	AM				
			Rg	1540	JH				
13/6/08			U	0055	QHS				U: 1mg
			U	1720	SE				(A) 1mg @ 1720
			~~F~~	~~2200~~	~~RM~~	ERROR			
14/6/08			Rg	15-30	PS				(E) - Self Admin
			W	16.35	AN				
			Y	22.10	PCH	LR			
15/6/08			Y	10.00	PS				(E) Nil Stock
			Rg	1515	SH	PS			
			Y	2145	PCH				
16/6/08			Y	14.00	E				
17/6/08			W	1900	SE	JH			
			Y	2205	PCH				
18/6/08			W	00-20	QHS				
19/6/08		2	SH						DERSTIVEN (E) SEE NEXT DUE 21/6/08
20/6/08									

NAME: LEON GRATTON UNIT No: FS153833 WARD: WOODBANK

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

PRESCRIPTION SHEET No.

KEY
A DRUG REFUSED
Ø 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
26/4/08																				R	2245	AM				
																				Sg	1835	PSE				
27/4/08																				R	2200	CRAM				
28/4/08																				Rg	1340	SBM				
																				R1	2210	AM				
29/4/08																				Rg2	0155	AM				Rg2 lg 0155
																				Sg	1440	BMS				

NAME: Lea Gralla UNIT No: F5153893 WARD: 2 QRUH DE CANTACH

MEDICINE RECORDING SHEET

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

PRESCRIPTION SHEET No.

KEY
Ⓐ DRUG REFUSED
Ⓐ̸ PATIENT ABSENT

Date	REGULAR PRESCRIPTIONS																	DEPOT INJECTION		AS REQUIRED						COMMENTS ON DISCREPANCIES
									OTHER TIMES																	
	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: ....

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

PRESCRIPTION SHEET No.

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
1/02/08					B	JM	A	AT									
2/02/08					B	MW	A	AT CR									
3/02/08					B	AM	A	AT CR									
4/2/08							A C	CR									
5/2/08							A C	AT CR									

DEPOT INJECTION

Code	Intls

AS REQUIRED

Code	Time	Intls	Code	Time	Intls
X	1505	AMM			
X	2340	CR			
X	0815	AM			
Ra	22.05	AT			
X		AT			

COMMENTS ON DISCREPANCIES

NAME: Leon Gratton UNIT No: F515

D.O.B: 17/03/75

WARD: Two

Dr. Cavanagh

MEDICINE RECORDING SHEET

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

PRESCRIPTION SHEET No.

KEY
Ⓐ DRUG REFUSED
Ⓐ̸ PATIENT ABSENT

	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: ....

Mental Health Directorate

ADMISSION INFORMATION SHEET [A1-1]

NHS

Initial admission to Ward/Department:	~~Community Service~~/Hospital:	Date 8/9/11 Time 16:10
2 (TWO)	QMH	
Consultant:	**Named Nurse/Case Manager**	**Unit No/CHI No** 1703751191
Lavanga	Jean Liz Isobel	F5153855
		Care Programme Approach No

Personal Information

FULL NAME: Mr / Mrs / Ms / Miss / Master	Where appropriate, likes to be known as:	Previous or Maiden Name(s)
Leon Gratton	Leon	N/A
	Date of Birth 17/3/75	**Place of Birth**
	Gender Male	Manchester
Home Address 3 Spitalfield Road Invertkeithing	**Current Address** → AS Before	**Marital Status** Single
Post Code	**Post Code**	**Telephone No(s)** 07922 56497
Present/Past Occupation Unemployed	**Religion and/or Chaplaincy requirement** None	**Ethnic Origin** White English **Sensory Impairment problem (s)** None
Allergies None Known	**Is English first language?** Yes ☑ No ☐ **Preferred Language**	**Is an interpreter required?** Yes ☐ No ☑ **Name (relationship to client, if any)**

MHA Status	Review Date	Patient Informed of Status By: / Date:	Clinical Risk Yes ☑ No ☐ If yes; Specify Main Risk	Does the Adults with Incapacity Act Apply; Yes ☐ No ☑
Inf			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	Home Address	Telephone No.
Mrs Leona Gratton	Unknown Post Code	07762 602112 Relationship: Mother
(2) Full Name	**Home address**	**Telephone No**
Mr Gary Gratton	57 Orchard Brae Manchester Post Code	0161 776 1420 Relationship: Father
Does service user agree with the sharing of information with Carer / Nearest Relative /Partner Yes ☐ No ☐	**Identify person to be contacted if patient is sick, dying or in any emergency.**	**Where appropriate - Order of Contact**

Mental Health Directorate

ADMISSION INFORMATION SHEET [A1-1]

Patients Name ..... Leon Grafton ..... Unit/CHI No FS153833 1703751191

Diagnosis

Relevant Medical Condition:	**Medication Concordance:**
Schizophrenia B.P.D Eczema Astma	As Per Kardex

Community Service Involvement

	Name/Address	**Tel No's**
LMHT/Community Team	Dawn Stanley c/o Haldane House	01383 432 725.
General Practitioner	Dr Garmany - Inverkeithing Med Practice	01383 413 234
Social Worker	Fiona Hunter	01383 4411 77
Community Psychiatric Nurse		
District Nurse		
Care Programme Approach Co-ordinator		
Home Care Manager		
Chaplain		
Dependants		
Other involvement Richmond	Dave Chaplin	01383 622 133

Patient Financial Information etc

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

Nursing Observations

Temperature	Pulse	Blood Pressure
36.3	115	117/76

Signature of Person Completing this Form: BL Date: 8/9/11

Mental Health Directorate

ADMISSION INFORMATION SHEET [A1-1]

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

Personal Information

FULL NAME: ~~Mr / Mrs / Ms / Miss / Master~~ LEON GRATTON	**Where appropriate, likes to be known as:** LEON	**Previous or Maiden Name(s)**
	Date of Birth 17-03-75 **Gender** MALE	**Place of Birth** MANCHESTER.
Home Address 5 SPITTALFIELD ROAD. OVERLEITHING **Post Code**	**Current Address** **Post Code**	**Marital Status** **Telephone No(s)** 07922956497 ~~0787 191 1072~~
Present/Past Occupation UNEMPLOYED	**Religion and/or Chaplaincy requirement** NONE	**Ethnic Origin** WHITE **Sensory Impairment problem (s)** NONE
Allergies NONE KNOWN	**Is English first language?** Yes ☑ No ☐ **Preferred Language**	**Is an Interpreter required?** Yes ☐ No ☑ **Name (relationship to client, if any)**

MHA Status	Review Date	Patient Informed of Status By: / Date:	Clinical Risk	Does the Adults with Incapacity Act Apply;	Is there an Identified Relapse Signature?
IF			Yes ☑ No ☐ If yes; Specify Main Risk: SEE RISK ASSESSMENT. Refer to Care Plan No _____	Yes ☐ No ☑	Yes ☐ No ☑ If Yes; Refer to Care Plan No _____

Main Carer/Partner/Relatives/Named Person Information etc

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

No information to be given to leons mother - 27/6/10

No information to leons mother - 5-4-11

Mental Health Directorate

ADMISSION INFORMATION SHEET [A1-1]

Patients Name ...LEON GRATTON..... Unit/CHI No ...F5153833.....

Diagnosis

Relevant Medical Condition:	**Medication Concordance:**
SCHIZOPHRENIA. BPD. ECZEMA ASTHMA	Collects oral meds daily from pharmacy Flupentixol 150mgs 1/52 - engages reasonably well - attends depot clinic with prompt.

Community Service Involvement

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

ient Financial Information etc

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

Nursing Observations

Temperature	Pulse	Blood Pressure

Signature of Person Completing this Form: D Stanley Date: 14-3-10.

Mental Health Directorate

ADMISSION INFORMATION SHEET [A1-1]

Initial admission to Ward/Department: 2.	**Community Service/Hospital:** Q.M.H.	Date at 10/08. Time 1700hrs
Consultant: Dr CAVANAGH.	**Named Nurse/Case Manager** Act Shirley Eddie.	**Unit No/CHI No**
		Care Programme Approach No

Personal Information

FULL NAME: (Mr) / Mrs / Ms / Miss / Master Leon Gratton.	**Where appropriate, likes to be known as:** Leon.	**Previous or Maiden Name(s)**
	Date of Birth 17/03/95. **Gender** male.	**Place of Birth** Manchester
Home Address 85 Spittalfield Rd Invercarthing. st Code	**Current Address** Post Code	**Marital Status** **Telephone No(s)** 415625 07516623988
Present/Past Occupation Unemployed.	**Religion and/or Chaplaincy requirement**	**Ethnic Origin** **Sensory Impairment problem (s)**
Allergies None Known.	**Is English first language?** Yes ☑ No ☐ **Preferred Language**	**Is an Interpreter required?** Yes ☐ No ☑ **Name (relationship to client, if any)**

MHA Status	Review Date	Patient Informed of Status By: / Date:	Clinical Risk	Does the Adults with Incapacity Act Apply;
1/f.			Yes ☑ No ☐ If yes; Specify Main Risk: Physical aggression when unwell or under influence of alcohol/drugs. Refer to Care Plan No _____	Yes ☐ No ☑ Is there an Identified Relapse Signature? Yes ☐ No ☑ If Yes; Refer to Care Plan No _____

Main Carer/Partner/Relatives/Named Person Information etc

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

Mental Health Directorate

ADMISSION INFORMATION SHEET [A1-1]

Patients Name ..Leon Gratton..... Unit/CHI No .....

Diagnosis

Relevant Medical Condition:	**Medication Concordance:**

Community Service Involvement

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

Patient Financial Information etc

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

Nursing Observations

Temperature 36.2.	Pulse 72.	Blood Pressure 126/82.

Signature of Person Completing this Form: A. Nurse. Date:

Mental Health Directorate

ADMISSION INFORMATION SHEET [A1-1]

Initial admission to Ward/Department: QMH	**Community Service/Hospital:** 2	Date 19.1.18 Time 11.55
Consultant: DR CAVANAGH	**Named Nurse/Case Manager** LINDA ANDY ISOBEL	**Unit No/CHI No** FS153833
		Care Programme Approach No

Personal Information

FULL NAME: (Mr) / Mrs / Ms / Miss / Master LEON GRATTON	**Where appropriate, likes to be known as:** LEON	**Previous or Maiden Name(s)** /
	Date of Birth 17/3/75 **Gender** MALE	**Place of Birth** MANCHESTER
Home Address 88 SPITTALFIELD INVERKEITHING **Post Code**	**Current Address** SIA. **Post Code**	**Marital Status** Single. **Telephone No(s)** ✓
Present/Past Occupation UNEMPLOYED	**Religion and/or Chaplaincy requirement** NONE	**Ethnic Origin** Scottish **Sensory Impairment problem (s)** NONE
Allergies NONE	**Is English first language?** Yes ☑ No ☐ **Preferred Language**	**Is an Interpreter required?** Yes ☐ No ☑ **Name (relationship to client, if any)**

MHA Status	Review Date	Patient Informed of Status By: / Date:	Clinical Risk Yes ☐ No ☑ If yes; Specify Main Risk / Refer to Care Plan No _____	Does the Adults with Incapacity Act Apply; Yes ☐ No ☑ / Is there an Identified Relapse Signature? Yes ☐ No ☑ If Yes; Refer to Care Plan No _____
Informal				

Main Carer/Partner/Relatives/Named Person Information etc

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

Mental Health Directorate

ADMISSION INFORMATION SHEET [A1-1]

Patients Name .LEON GRATTON..... Unit/CHI No .FS153883

Diagnosis

Relevant Medical Condition:	**Medication Concordance:**
SCHIZOPHRENIA	AS PER KARDEX

Community Service Involvement

	Name/Address	Tel No's
LMHT/Community Team		
General Practitioner DR GARMONY	INVERKEITHING MEDICAL CENTRE	
Social Worker		
~~Community Psychiatric Nurse~~ WFCOT		01383-432725.
District Nurse		
Care Programme Approach Co-ordinator		
Home Care Manager		
Chaplain		
Dependants		
Other involvement	Richmond - moray	01383 622135

Patient Financial Information etc

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

Nursing Observations

Temperature 36.3	Pulse 66	Blood Pressure 131/67

Signature of Person Completing this Form: [signature] Date: 10/6/18

Mental Health Directorate

ADMISSION INFORMATION SHEET [A1-1]

Initial admission to Ward/Department: Woodbank	**Community Service/Hospital:** WBH	Date 8/6/08 Time 20:30
Consultant: Dr smith	**Named Nurse/Case Manager** Jean Braid	**Unit No/CHI No** F515833
		Care Programme Approach No

Personal Information

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

Main Carer/Partner/Relatives/Named Person Information etc

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

Mental Health Directorate

ADMISSION INFORMATION SHEET [A1-1]

Patients Name Leon Gratton Unit/CHI No F5153833

Diagnosis

Relevant Medical Condition:	**Medication Concordance:**
Hx Schizophrenia	Poor compliance with prescribed medication.

Community Service Involvement

	Name/Address	**Tel No's**
LMHT/Community Team		
General Practitioner Dr Garmony	Invergowrie Medical Centre	
Social Worker		
Community Psychiatric Nurse		
District Nurse		
Care Programme Approach Co-ordinator		
Home Care Manager		
Chaplain		
Dependants		
Other involvement	Richmond - Morag.	01383 622133

Patient Financial Information etc

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

Nursing Observations

Temperature 35.1°	Pulse 113/70	Blood Pressure 66

Signature of Person Completing this Form: A. Nland Date: 8.6.08

Mental Health Directorate

ADMISSION INFORMATION SHEET [A1-1]

Initial admission to Ward/Department: WARD	**Community Service/Hospital:** QMH	Date 25/4/08 Time 2030
Consultant: DR CAVANAGH	**Named Nurse/Case Manager**	**Unit No/CHI No** / **Care Programme Approach No**

Personal Information

FULL NAME: **Mr / Mrs / Ms / Miss / Master** Leon James Gratton	**Where appropriate, likes to be known as:** / **Date of Birth** 27/3/75 / **Gender** M	**Previous or Maiden Name(s)** / **Place of Birth**
Home Address 85 Spittal Field Rd Invertkeithing **Post Code** KY11 1DZ	**Current Address** / **Post Code**	**Marital Status** / **Telephone No(s)** 01383 415625
Present/Past Occupation 'UNEMPLOYED	**Religion and/or Chaplaincy requirement**	**Ethnic Origin** / **Sensory Impairment problem (s)** NONE
Allergies NONE KNOWN	**Is English first language?** Yes ☑ No ☐ **Preferred Language**	**Is an Interpreter required?** Yes ☐ No ☑ **Name (relationship to client, if any)**

MHA Status	Review Date	Patient Informed of Status By: / Date:	Clinical Risk Yes ☐ No ☑ If yes; Specify Main Risk / Refer to Care Plan No _____	Does the Adults with Incapacity Act Apply; Yes ☐ No ☐ / Is there an Identified Relapse Signature? Yes ☑ No ☐ Assistance / If Yes; Refer to Care Plan No _____
Informal				

Main Carer/Partner/Relatives/Named Person Information etc

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

Mental Health Directorate

ADMISSION INFORMATION SHEET [A1-1]

Patients Name ..... Unit/CHI No .....

Diagnosis

Relevant Medical Condition:	**Medication Concordance:**
Eczema Asthma	Clopixol Depot Nitrazepam Diazepam

Community Service Involvement

	Name/Address	**Tel No's**
LMHT/Community Team Dawn'	WFCOT Team	432 725
General Practitioner	Dr GARMANY – Investigations Signs	413234
Social Worker		
Community Psychiatric Nurse	Tom Short – WFCOT	
District Nurse		
Care Programme Approach Co-ordinator		
Home Care Manager		
Chaplain		
Dependants		
Other involvement	Richmond Fellowship	01388 622153

Patient Financial Information etc

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

Nursing Observations

Temperature	Pulse	Blood Pressure

Signature of Person Completing this Form: Date:

Fife Primary Care Division – Mental Health Directorate

ADMISSION INFORMATION SHEET [A1-1]

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

Personal Information

NAME LEON GRATTON	**Where appropriate, likes to be known as:** LEON	**Maiden Name** N/A.
	Date of Birth 17.3.75	**Place of Birth** Manchester
Home Address 85 SPITTALFIELD RD. NUERKEITHING. **Post Code**	**Current Address** Same **Post Code**	**Telephone No** 415625 mob 07516623988
Present/Past Occupation UNEMPLOYED	**Religion and/or Chaplaincy requirement**	**Ethnic Origin** white **Sensory Impairment problem (s)** none
Allergies none known.	**Is English first language?** Yes ☑ No ☐ **Preferred Language**	**Is an Interpreter required?** Yes ☐ No ☑ **Name (relationship to client, if any)**
MHA Status Informal / **Review Date** / **Tribunal Date**	**Clinical Risk** Yes ☑ No ☐ **If yes; Specify Main Risk** POTENTIAL FOR PHYSICAL AGGRESSION WHEN MENTALLY UNWELL OR UNDER THE INFLUENCE OF ALCOHOL / DRUGS.	**Does the Adults with Incapacity Act Apply;** Yes ☐ No ☑ **Is there an Identified Relapse Signature?** Yes ☐ No ☑ **If Yes; Refer to Care Plan No** _____

Main Carer/Partner/Relatives Information etc

(1) Full Name LORNA GRATTON	**Home Address** ~~85~~ none given **Post Code**	**Telephone No.** 07762602112 **Relationship** MOTHER.
(2) Full Name none given Gary Gratton	**Home address** 570rchard ~~Brae~~ Manchester **Post Code**	**Telephone No** 01617761420 **Relationship** father
Does service user agree with the sharing of information with Carer / Nearest Relative /Partner Yes ☐ No ☑	**Identify person to be contacted if patient is sick, dying or in any emergency.** mother	**Where appropriate - Order of Contact** mother

Fife Primary Care Division – Mental Health Directorate

ADMISSION INFORMATION SHEET [A1-1]

Patients Name LEON GRATTON ..... Unit/CHI No .....

Diagnosis Schizophrenia - borderline personality Disorder

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

Community Service Involvement

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

Patient Financial Information etc

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

Nursing Observations

Temperature	Pulse	Blood Pressure
—	—	—

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

Fife Primary Care Division – Mental Health Directorate

ADMISSION INFORMATION SHEET [A1-1]

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

Personal Information

NAME LEON GRATTON	**Where appropriate, likes to be known as:** LEON **Date of Birth** 17.3.75	**Maiden Name** N/A. **Place of Birth** Manchester
Home Address 85 SPITTALFIELD RD. INVERKEITHING. **Post Code**	**Current Address** Same **Post Code**	**Telephone No** 415625 mob 07516623988
Present/Past Occupation UNEMPLOYED	**Religion and/or Chaplaincy requirement**	**Ethnic Origin** white **Sensory Impairment problem (s)** none
Allergies none known.	**Is English first language?** Yes ☑ No ☐ **Preferred Language**	**Is an Interpreter required?** Yes ☐ No ☑ **Name (relationship to client, if any)**
MHA Status Informal / **Review Date** / **Tribunal Date**	**Clinical Risk** Yes ☑ No ☐ **If yes; Specify Main Risk** POTENTIAL FOR PHYSICAL AGGRESSION WHEN MENTALLY UNWELL OR UNDER THE INFLUENCE OF ALCOHOL / DRUGS.	**Does the Adults with Incapacity Act Apply;** Yes ☐ No ☑ **Is there an Identified Relapse Signature?** Yes ☐ No ☑ **If Yes; Refer to Care Plan No** _____

Main Carer/Partner/Relatives Information etc

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

Fife Primary Care Division – Mental Health Directorate

ADMISSION INFORMATION SHEET [A1-1]

Patients Name LEON GRATTON ..... Unit/CHI No .....

Diagnosis Schizophrenia - borderline personality Disorder

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

Community Service Involvement

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

Patient Financial Information etc

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

Nursing Observations

Temperature	**Pulse**	**Blood Pressure**
—	—	—

Signature of Person Completing this Form: KarenARichards Date: 24/9/7

Patients Name Leon Carathon Unit/CHI No

8 Main Carer/relative's perception & understanding of illness
(including: understanding of diagnosis and likely prognosis, reasons for current admission and awareness of likely future placement)

9 Nursing observation of patient's mental state
(including: observations of initial behaviour and mental state, reaction to hospitalization, current level of orientation and potential problems in adaptation)

10 Nursing observation of patient physical state

Temperature 36.2. Pulse 72. Blood Pressure 126/82.

Urinalysis Skin State Intact. Glasses Hearing Aid

Dentures Dentures Marked: Yes ☐ No ☐

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

General Appearance

Distinguishing features

Height Weight Build Eye Colour

Hair colour Shoe Size Posture

12 Physical problems experienced at home/previous care setting
(including: level of mobility and walking skills, postural problems, weight loss, nutritional problems, continence problems, skin care problems and level of physical frailty)

13 Self Care problems experienced at home/previous care setting
(including: level of self-care problems, skills and abilities in washing, dressing, feeding, bathing and toileting)

14 Communication problems experienced at home/previous care setting
(including: level of verbal and non verbal communication skills/impairment, and problems, such as swearing, repetitive questioning, or verbal aggression)

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

ADMISSION ASSESSMENT / HISTORY TAKING [A1-1b Elderly]

Patients Name Leon Gratton. Unit No .....

16 Behaviour experienced (problems) at home/previous care setting
(including: persistent walking indoors and/or outdoors, repetitive behaviour, resistance to being cared for, episodes of verbal and/or physical aggression)

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

18 Emotional problems experienced at home/previous care setting

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

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

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

Fife Primary Care NHS Trust – Mental Health Directorate

Care Notes - Continuation Sheet [CN1B]

Page No.....

Patients/Client Name: Leon Gratton.

Unit/CHI Number:

Date: Time:	*Record of Important Information not held in Evaluation/Review/Variation etc*	Signature
2/2/18	Leon agrees to information being shared with his mother and father only	M Taylor

Fife Primary Care NHS Trust – Mental Health Directorate

Care Notes - Continuation Sheet [CN1B]

Page No……..

Patients/Client Name	Unit/CHI Number:

Date: Time:	*Record of Important Information not held in Evaluation/Review/Variation etc*	Signature

NHS Fife

Fife Primary Care NHS Trust – Mental Health Directorate

Care Notes [CN1]

Patients/Client Name: Leon Gratton.

Unit Number / CHI:

Date of Birth: 17/03/75.

Named Nurse/Key Worker: Aret; Shirley; Eddie.

Date: Time:	*Multi Disciplinary Record of Important Information not held in Evaluation/Review/Variation Records etc*	Signature
01/02/08. 16 00	Informal admission following referral by WFCOT. WFCOT had attended house to administer depot Leon complaining of derogatory + Command Suicide hallucinations reportedly took 8 Co-codamol ~~last night~~ recently, no recent stressors to current presentation; Seen on ward by Dr Ashrafh reported to not have slept last night due to "voices. hallucinations you name it"; reported same ongoing for 3-4 months increasing Value and intensity. Reportedly took last overdose last night of 8 paracetamol, took all in one go 2 at a time every 2hours with intention of "dying", reports no current Suicidal ideation or plans stating would not end life because of his son; States mood is low 3/10 Sleep 3-4hours a night. At interview speech normal in rate; tone; rythem with mood objectively euthymic. Bloods taken due to paracetamol overdose; Vital Stats taken on admission reading BP 126/82 P 72 Temp 36.2°c Plan, received depot on arrival to ward. Admit Informally General obs On call doctor to check bloods Can have passes in hospital grounds at staff discretion	
20 12	Leon quickly settled on ward spending time between bedroom and courtyard; visited by his mother however not willing to speak with his mother. mother met with staff however Leon not wishing for information to be passed on; only wishing for mother to be told he was fine and will get things sorted out.	A Anastasiya
2.2.08 06 45	Leon spoke of reasons for admissions believes its still due to Gabin's death 1 year ago last ~~night~~ week. Woken for night-d sedation and slept well until 06:30hrs.	Thaill
11 44	Leon early to rise does not appear to have attended to personal care complaining of a headache however not able to receive any analgesia due to awaiting blood levels taken on 1/2/08, Leon stating the headache appears to come and go advised to drink fluids and get some fresh air until results are received from the lab.	Anastasiya
21 10.	No management problem Complaining at times of ~~GOC~~ headache and noted to be laughing out loud & himself at one point saying that music on Sky+ts made him think of "Homer Simpson"	A. Hutton
2120	Then Dr Olley Paracetamol results not	

Patients/Client Name: LEON GRATTAN

Unit/CHI Number:

Date: Time:	*Record of Important Information not held in Evaluation/Review/Variation etc*	Signature
2120	high enough to require treatment.	
3.3.08	Leon requested & given IBUPROFEN at 23.10hrs	
07.05	Has slept little overnight. Only goes outside to smoke if staff present in day-room.	
1250	Leon has presented as reasonably settled. He has been heard to respond openly on several occasions to unknown stimuli, time spent between bed area and day room/courtyard. No complaints offered.	
3/2/08 2000	Leon has presented as settled in presentation. No evidence of him responding to any unknown stimuli. Visited by his mother noted to have had a heated discussion with her she visited again later with some belongings for him which she had in her own house. She stated that he had asked him to go to ~~her flat~~ his house however she refuses to do this as he ~~partner~~ normally blames her for stealing his belongings	
4/2/08 0640	(NR) Leon has remained settled with no new problems slept well overnight.	
1403	Dr Cavanagh Pts mtng. – taken from notes. Reports increased "voices" derogatory in nature, reports to & not being as "depressed" and "lonely" in hospital. Mother visited yesterday arguing all the time i phoned mother after overdose last week; phoning Samaritans at times rather than mother as mother becomes annoyed – feels unsupported. Plan Increase depot to Flupenthixol 100mg Diazepam reduced to 6mg. aim for discharge midweek.	AMA/SWN.
2015hrs	TENDING TO KEEP HIMSELF TO HIMSELF THIS AFTERNOON/EARLY EVENING SPENDING MUCH OF HIS TIME SITTING AT HIS BED AREA, ALTHOUGH WITH OCCASSIONAL VISITS TO SITTING AREA. LITTLE INTERACTION OFFERED ALTHOUGH PLEASANT ON APPROACH.	
(CONT)	– CURRENTLY SITTING IN HIS BED AREA APPROPRIATE & BRIGHT IN MOOD SHARING A JOKE WITH FELLOW PATIENTS IN THE DAY AREA.	
5/2/08 0655	(NR) Leon retired to bed late into night still	

Fife Primary Care NHS Trust – Mental Health Directorate

Care Notes - Continuation Sheet [CN1B]

Patients/Client Name: Leon Gratton

Unit/CHI Number:

Date: Time:	*Record of Important Information not held in Evaluation/Review/Variation etc*	Signature
NR Contd	Continues to attempt smoking in dayroom despite reminders from staff regarding policy on same.	
5/2/08 09.20	Belated entry from 4/2/08 – p.m. Leon had short period off ward in the company of his Richmond Fellowship Support Worker, Neil yesterday evening. Hazel, Support Worker will escort Leon home on pass for 3 hours 5/2/08 to collect belongings he requires.	A Graham
02.25	Leon has been settled overnight on the ward, although noted to be responding to unknown stimuli. Was visited for a short period of time then own by his mum.	A Taylor
5.2.8	(2030hrs) Leon appearing bright and settled in presentation spending time socialising with fellow patients in music room. Planned discharge on 6/2/08 discharge prescription completed. No concerns highlighted.	M Tipon
6.2.08 07.15	Analgesia for headache. Remains settled slept well.	T Traill
15.10	Telephone call received from Leon's mum confirming discharge today. Informed planned for later this afternoon. Asked to pass a message that she will contact him to meet at his home. Some given. Leon stated during the interview he will be staying at [illegible] with discharge medication. Letter to be posted.	DN
16.10	Leon was discharged today from the ward. Medication supplied, contacted his GP, NFCOT and Richmond house. Kardex for depot sent to Carnegie Clinic.	S Bain

Fife Primary Care NHS Trust – Mental Health Directorate

Care Notes - Continuation Sheet [CN1B]

Page No........

Patients/Client Name	Unit/CHI Number:

Date: Time:	*Record of Important Information not held in Evaluation/Review/Variation etc*	Signature

Fife Primary Care Division
Mental Health Directorate

NHS Fife

Observation Care Plan - GENERAL

Patient's Name Leon Gratton DOB 19/3/75 CHI/Unit No. .....

Ward 2. Responsible Consultant Dr Cavanagh.

Physical Description

Height		Hair	
Weight		Build	Tall/medium
Eye Colour		Dist. Features	

GENERAL Observation Level

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

Reason for level / Specific risks identified

Assessment of mood & mental state.

Specific interactions and limits to be applied

Prescribing Nurse Signature A MATSWA. Grade Band 5 Date 01/3/08.

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

Nursing Signature ..... Date .....

Medical Signature ..... Date .....
(Note: A medical signature is not essential when raising the observation level)

Review Notes Overleaf

REVIEW NOTES

Date	Observations / Decisions	Nurse's Signature

Patients Name ..... LEON GRATTAN ..... Unit/CHI No .....

8 Main Carer/relative's perception & understanding of illness
(including: understanding of diagnosis and likely prognosis, reasons for current admission and awareness of likely future placement)

9 Nursing observation of patient's mental state
(including: observations of initial behaviour and mental state, reaction to hospitalization, current level of orientation and potential problems in adaptation)

Thoughts of overdose or self harm
and increased hearing voices.

10 Nursing observation of patient physical state

Temperature _____ Pulse _____ Blood Pressure _____

Urinalysis _____ Skin State _____ Glasses _____ Hearing Aid _____

Dentures _____ Dentures Marked: Yes ☐ No ☐

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

General Appearance _____

Distinguishing features _____

Height _____ Weight _____ Build _____ Eye Colour _____

Hair colour _____ Shoe Size _____ Posture _____

12 Physical problems experienced at home/previous care setting
(including: level of mobility and walking skills, postural problems, weight loss, nutritional problems, continence problems, skin care problems and level of physical frailty)

Physically - OK.

13 Self Care problems experienced at home/previous care setting
(including: level of self-care problems, skills and abilities in washing, dressing, feeding, bathing and toileting)

14 Communication problems experienced at home/previous care setting
(including: level of verbal and non verbal communication skills/impairment, and problems, such as swearing, repetitive questioning, or verbal aggression)

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

NHS Fife – Mental Health

ADMISSION ASSESSMENT / HISTORY TAKING [A1-1b Elderly]

Patients Name Leon Grattan ..... Unit No .....

16 Behaviour experienced (problems) at home/previous care setting
(including: persistent walking indoors and/or outdoors, repetitive behaviour, resistance to being cared for, episodes of verbal and/or physical aggression)

Denies Alcohol or Substances

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

Works with fitness - weights at home.

Isolated - little social contact.

18 Emotional problems experienced at home/previous care setting

Arrantsy.

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

Admission following referral from Wheat.

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

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

Occupational Health and Safety Advisory Service / January 2002

Client Handling Assessment Form

A. Client Details/Assessment

A. Client details	Date		
	Weight kg:		
	Height mtrs:		
	BMI		

Weight Bearing: yes/no

Full/Partial/variable

History of Falls: yes/no (please circle)

Equipment used by client:
wheelchair stick
hoist other .....
zimmer
rollator

Physical condition

Client's comprehension / communication

Handling constraints:

Behaviour which may effect safe handling:

Rehabilitation Programme:

Action plan discussed with client/carer yes/no

Date: Signature: Designation:

NHS Fife

Fife Primary Care NHS Trust – Mental Health Directorate

Care Notes [CN1]

Patients/Client Name: Leon Crattan

Unit Number / CHI:

Date of Birth:

Named Nurse/Key Worker:

Date: Time:	*Multi Disciplinary Record of Important Information not held in Evaluation/Review/Variation Records etc*	Signature
25/4/08	Leon is a gentleman known to services with a Psychotic illness who has been contacting the west fife community outreach team on a couple of occasions today as this is a home visit by SLN Dawn Stanley. He reported to them intent to take an overdose of diazepam and paracetamol, also slimming tablets, plans also to drink bleach and has access to these substances at home. This led to him being brought to ward for assesment by Dr Khan. He reports depressive symptoms over past few weeks and increased hearing voices telling him derogatory comments about himself. He also says that his neighbours are making too much noise and he needs less rest from this and Leon was keen for admission also claims that he felt like killing himself and his neighbour. Reports poor appetite and poor sleep, however, he was taking ? appetite suppressants - slimming pills. Currently lives alone but has had a recent argument with his mother which has been a factor in precipitating his admission. Dse to intent to harm himself if not admitted and also has the means to carry out this. Plan from Dr Khan: • Admission to hospital due to risk of overdose / self harm • Assessment in ward 2 over weekend • Physical + bloods tomorrow • No passes. —— S. Ek	
26/4/08 0630	Leon has been settled in presentation socialized well within the dayroom, prior to retiring a has slept well overnight. —— C. Reid	
26.4.08 12.15pm	Duration of the morning has been spent asleep in bed, remains there at time of reporting. —— M Callaghan	
21-15	Settled in presentation, since adm Diazepam 5mg, as per Rapid, Dr. Kumbahan to review Rapid with Leon this evening. Escorted pass to shop - no problems noted —— C Reid	

Patients/Client Name: Leon Gardiner

Unit/CHI Number:

Date: Time:	*Record of Important Information not held in Evaluation/Review/Variation etc*	Signature
29/4/08 06.50 (N2)	Leon presenting as settled pleasant and appropriate given Nitrazepam 10mg at 22.45 hrs retired to bed before midnight and appears to have slept well overnight	A Andrew A
12.50	Leon up early, not attended to care needs - settled in manner, time spent between bed area and courtyard	C Payne
19.55	Presenting as settled around the ward spending time in dormitory mainly. Leon was asked and declined the ward based relaxation group.	T Schiavone
28/4/08. 07.00.	Settled in presentation bright & sociable with fellow clients in dayroom. Given PRN NITRAZEPAM 10mgs at 22.00hrs. Late to settle appears to have slept from around 0h.00hrs	clad
28/4/8	Dr Cavanagh ward round - taken from notes * Admitted to hearing voices/suicidal thoughts * Has been stressed due to social circumstances * Insomnia ~~wo~~ * Had increased depot 2 weeks ago feels it helped * Voices have improved since admission. * 2 more days in the ward to review mental state * Passes increased to 4hrs if he needs to go home to get clothes.	MRCP
12.05hrs	Awake early, unsure if attended to personal care needs. Contacted west fife community mt reach team to advised them of his admission to ward 2. presenting as stable in mood and mental state throughout morning	S Simms
2100.	Appeared relaxed and settled until some time after Seven he stormed off the ward. He came back a few minutes later ignoring me when I asked if he had been to the Vending machine. Some time later, still looking troubled, I asked if anything was wrong He said he was being raped, "fucked up the ass" all the time. I didn't ask him to elaborate. S/N ~~Schiavone~~ Schiavone later told me that he had again asked for diazepam. When told it was a Once only he left, only shrugging his shoulders. When I	

Fife Primary Care NHS Trust – Mental Health Directorate

Care Notes - Continuation Sheet [CN1B]

Patients/Client Name: Leon Gratton

Unit/CHI Number:

Date: Time:	*Record of Important Information not held in Evaluation/Review/Variation etc*	Signature
28/4/8 2100	next saw him I asked if the two ~~incid~~ incidents were connected. He only said that "it would help." SCN Gibson told me later that Leon Gratton and S.C were talking when the latter asked "did you get anything?" Dr. Richardson, duty doctor, was told of all that had transpired some time after, ~~after~~ after Leon spoke with S/N Schiavone, Dr. Richardson prescribed him a once only diazepam 15mg.	M Anderson
29/4/08 n/a 07-15	Has not slept overnight requested a dose. given Nitrazepam 10mg at 22-10 hr but this has had no effect. Has spent the night going between day room and bedroom. Mood appears bright. Laughing in the company of others.	Lmcd
11-35	Leon has been settled around the ward he went to the cafe with his support worker	SRae
4.30pm	Leon approached myself requesting discharge home. Contacted Dr Ratnaswamy who arrived on ward to meet with Leon re - request for discharge home. Feedback from Dr Ratnaswamy after review: Leon to be discharged home tonight. Follow up outpatients with Dr Cavanagh, west fife community ~~outreach~~ team 3 x weekly and Richmond Fellowship 5 x weekly.	SCarmichael
6pm	GP, WFCST and Richmond Fellowship advised of Leon discharge. Discharge medication issued as per discharge script. Repeats and risk assessments ~~staff~~ to be completed for WFCST. ~~Telephone~~ Telephone call received from pharmacy enquiring about frequency of diazepam medication. S/N Schiavone Schiavoni clarified same with Dr Ratnaswamy that Leon only to be given 1 x dose of diazepam 5mg / as same issued daily when in community. Pharmacy advised of the above	SLennie

Fife Primary Care NHS Trust – Mental Health Directorate

Care Notes - Continuation Sheet [CN1B]

Page No……..

Patients/Client Name

Unit/CHI Number:

Date: Time:	*Record of Important Information not held in Evaluation/Review/Variation etc*	Signature

Fife Primary Care Division
Mental Health Directorate

NHS Fife

Observation Care Plan - GENERAL

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

Ward 2 Responsible Consultant Dr Cavanagh

Physical Description

Height		Hair	
Weight		Build	
Eye Colour		Dist. Features	

GENERAL Observation Level

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

Reason for level / Specific risks identified

Intent to self Harm

Specific interactions and limits to be applied

Respite Admission

Prescribing Nurse Signature ..... Grade ..... Date 05.6.08

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

Nursing Signature ..... Date .....

Medical Signature ..... Date .....
(Note: A medical signature is not essential when raising the observation level)

Review Notes Overleaf

Fife Primary Care NHS Trust – Mental Health Directorate

Care Notes - Continuation Sheet [CN1B]

Page No……..

Patients/Client Name

Unit/CHI Number:

Date: Time:	*Record of Important Information not held in Evaluation/Review/Variation etc*	Signature

Mental Health Risk Assessment Checklist

Patient/Client Name LEON GRATTON

Date of Birth 1/1/15 CHI/Unit No 1191

Past History

History of Violence (ever)

	Tick
None home	☐
One incident	☐
Two incidents	☐
Three incidents	☐
More than three incidents	☑

Most serious harm caused

None	☐
Minor injury	☑
Serious injury	☐
Fatality	☐

History of Suicide attempts (ever)

None	☐
One	☑
Two	☐
Three	☐
More than three	☐

History of severe self neglect (ever)

No ☐ Yes ☑

History of risk to children (ever)

No ☑ Yes ☐

History of containment (ever)

State Hospital	No ☐	Yes ☐
Secure Care	No ☐	Yes ☑
Prison	No ☐	Yes ☐
PICU/Locked ward	No ☐	Yes ☐
Compulsory Admission	No ☐	Yes ☐
Temp Detention at Police Station	No ☐	Yes ☑

Incidents involving the Police (past year) (ever)

None	☐
One	☐
More than one	☑

History of failure to take medicine

No ☐ Yes ☑

History of unplanned cessation of contact

No ☑ Yes ☐

Known Problems over the last year - ever

Tick all problems presented	(in past year)	(ever)
Accident harm at home (eg, falling, careless smoking)	☐	☐
Accident harm outside the home eg, wandering into road	☐	☐
Alcohol abuse	☐	☑
Arson (deliberate fire-setting only)	☐	☐
Drug abuse	☐	☑
Overdose	☐	☐
Risk of abuse from others	☐	☑
Risk to children	☐	☐
Self-injury (eg, cutting)	☐	☐
Other methods of self harm (specify).		
Self-neglect	☐	☐
Sexual Assault	☐	☐
Violence to family	☐	☑
Violence to staff	☐	☐
Violence to other patients	☐	☐
Violence to the general public	☐	☐
Violence to specific other	☐	☐

Other (specify) MOTHER CAN BE AT RISK FROM LEON, ALSO LEONS STEPFATHER

Patient/client name LEON GRATTAN ..... CHI/Unit No .....

Detail of nature of risk:

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

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

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

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

Plan of Action

Date time of completion 1:8:06

Name in Block Capitals TOM SHORT

Designation C.C.M.

Signature T. Short

Care Pathways

Fife Primary Care NHS Trust - Mental Health Directorate

Acute Inpatient - Admission to Hospital [F1]

NHS Fife

Ward /Dept 1W2

Name: Leon Grattan

Care Plan Number: 1

C.H.I. Number: 1703751191

Unit Number: F5153833

Date Commenced: 10/06/08

Consultant/G.P.: Dr. Cavanagh.

Prescribed By Named Nurse: A. Anderson

Date Resolved:

Description of Need:

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

Objective/Expected Outcome

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

Actual Outcome

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

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

ACTION TO BE TAKEN: - CARE PLAN – Admission to Acute Ward	Date	Signature
1. Implement observation level as prescribed by multidisciplinary team in accordance with Trust /hospital policy and procedure.	10/06/05	A. Aulcorn
2. Observe client's behaviour, social interactions and participation in activities.		
3. One to one patient interactions enable collection of information on the client's mental state and the problems that they perceive.		
4. Liaise with members of the multidisciplinary team regarding client's mental/physical status.		
5. Administer medication as prescribed.		
6. Report and record all observations and any information gained from patients interaction accurately		
7. Liaise with carers and relatives to gain a comprehensive profile of presenting problems	✓	✓
8. *Individual Nursing Actions Required:* -		

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

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

.....

NHS Fife – Mental Health

ADMISSION ASSESSMENT / HISTORY TAKING [A1-1b Elderly]

NHS Fife

Patients Name LEON GRATTON Unit/CHI No F.S.S.3883/1191

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

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

9 Nursing observation of patient's mental state

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

10 Nursing observation of patient physical state

Temperature 36.3 Pulse 66 Blood Pressure 131/67

Urinalysis N.A.D. Skin State Intact Glasses NO Hearing Aid

Dentures NO Dentures Marked: Yes ☐ No ☐

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

General Appearance Well kept

Distinguishing features TATOO LEFT SNAKE

Height 6'2 Weight 13 stone Build MEDIUM Eye Colour BLUE

Hair colour BROWN Shoe Size Posture UPRIGHT

12 Physical problems experienced at home/previous care setting

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

NO PROBLEMS AT PRESENT

13 Self Care problems experienced at home/previous care setting

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

INDEPENDENT OF CARE

14 Communication problems experienced at home/previous care setting

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

NO PROBLEMS NOTED, LEON ALSO

15 Confusion problems experienced at home/previous care setting

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

CAN GET CONFUSED AT TIMES

NHS Fife – Mental Health

ADMISSION ASSESSMENT / HISTORY TAKING [A1-1b Elderly]

Patients Name ... Unit No FS153833/1191

16 Behaviour experienced (problems) at home/previous care setting
(including: persistent walking indoors and/or outdoors, repetitive behaviour, resistance to being cared for, episodes of verbal and/or physical aggression)

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

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

18 Emotional problems experienced at home/previous care setting

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

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

PREVIOUS ADMISSIONS TO WARD TWO

Fife Primary Care Division
Mental Health Directorate

NHS Fife

Observation Care Plan - GENERAL

Patient's Name LEON GRATTAN DOB 17:3:75 CHI/Unit No F5153833

Ward WOODBANK Responsible Consultant Dr SMITH

Physical Description

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

GENERAL Observation Level

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

Reason for level / Specific risks identified

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

Specific interactions and limits to be applied

~~Nil time out at present.~~

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

Prescribing Nurse Signature K. Yland Grade SIN Date 8:6:08

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

Nursing Signature ..... Date .....

Medical Signature ..... Date .....
(Note: A medical signature is not essential when raising the observation level)

Review Notes Overleaf

NHS Fife

REVIEW NOTES

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

ADMISSION SUMMARY ANALYSIS [A1-2 Dementia]

To be completed within 48 –72 hrs of admission

NHS Fife

Patients Name Leon Grattow Unit/Chi No F5153833 (7037511911.

[1] Memory/orientation needs:

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

[2] Behaviour needs:[*Mental State*]

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

[3] Communication needs: [*Social interaction*]

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

[4] Mood disturbance needs:{[*Mental State*]

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

[5] Sleep needs:

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

[6] Continence needs [*Toileting*]

No problems regarding this area of functioning.

[7] Washing/dressing needs [*Self care*]

Independent in attending to his self-care needs.

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

No issues with regard to nutrition.

Patients Name Leon Gratton Unit/CHI No F5153833 / 1703751191

[9] Mobility needs

Nil problems ; mobilises independently.

[10] Skin/pressure care needs

Nil problems ; skin intact.

[11] Physical health/pain needs

No problems or concerns with regard to physical health.

[12] Medication

Receiving depot , flupenthixol , without protest.
Recently commenced on above but in tablet form with no reports of ill effects thus far.

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

Reports no difficulties with respect to this.

[14] Community Services

Receives community input from WFCOT and Richmond.

[15] Financial/clothing needs

Reports no difficulties with regard to financial / clothing needs.

Emotional / Psychological needs:

Is Patient / Client in receipt of pension book: Yes ☐ No ☑

Specify _____

Who holds Pension Book _____ Who holds house keys _____

Signature: A. Anderson S/W.

CLIENT HANDLING ASSESSMENT FORM

A. Client Details/Assessment

A. Client details				
LEON GRATTAN 85 SULTAN FIELD ROAD INVERKEITHING FS153833.		**Date**	8.6.08	
		Weight kg:	84kg	
		Height metres:	1.88m	
		BMI	24	

Weight Bearing: yes/no

Full/Partial/variable

History of Falls: Yes/No *(please circle)*

Equipment used by client:

Wheelchair	Stick
Hoist	Other... NONE
Zimmer	.....
Rollator	.....

Physical condition

Good at present.
Suffers from eczema.

Client's Comprehension/communication

Can communicate freely. Is able to understand instruction. Orientated to time, place & person. No formal testing carried out.

Handling constraints:

None at present.

Behaviour which may affect safe handling:

None known at this time.

Action plan discussed with client/carer yes/no

Date: 8.6.08 **Signature:** A. Mcnamara **Designation:** S/N

B. Review Date:	Comments/reasons for one off assessment/technique	Signature:

B. Review Date:	Comments/reasons for one off assessment/technique	Signature:

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

C. Review Date:	Comments/reasons for one off assessment/technique	Signature:

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

TASK No.... :	TASK No.... :
Number of staff required ..... Mechanical Hoist Required: Yes/No Type: Sling size/colour Other moving and handling equipment: sling type Handling Instructions:	Number of staff required ..... Mechanical Hoist Required: Yes/No Type: Sling size/colour Other moving and handling equipment: sling type Handling Instructions:
Signature: Date:	Signature: Date:
TASK No.... :	**TASK No.... :**
Number of staff required ..... Mechanical Hoist Required: Yes/No Type: Sling size/colour Other moving and handling equipment: sling type Handling Instructions:	Number of staff required ..... Mechanical Hoist Required: Yes/No Type: Sling size/colour Other moving and handling equipment: sling type Handling Instructions:
Signature: Date:	Signature: Date:

C: Client Handling Action Plan

Client Name: **D.O.B:** **HOSPITAL NO:**

TASK No.... : Number of staff required ..... Mechanical Hoist Required: Yes/No Type: Sling size/colour sling type Other moving and handling equipment: Handling Instructions: Signature: Date:	**TASK No.... :** Number of staff required ..... Mechanical Hoist Required: Yes/No Type: Sling size/colour sling type Other moving and handling equipment: Handling Instructions: Signature: Date:
TASK No.... : Number of staff required ..... Mechanical Hoist Required: Yes/No Type: Sling size/colour sling type Other moving and handling equipment: Handling Instructions: Signature: Date:	**TASK No.... :** Number of staff required ..... Mechanical Hoist Required: Yes/No Type: Sling size/colour sling type Other moving and handling equipment: Handling Instructions: Signature: Date:

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

Name: Leon Gratton Date of Birth: 17 / 03 / 75 CHI/Unit No: F5153833

Address: 85 Spittal Field Road, Inverkeithing chi: 1703751191

Post Code: KY11 1DZ. Gender Male

Date of Assessment: 25 / 06 / 08 Time: Review Date: / /

Category of Risk	Assessment of Risk
From Others (e.g. abuse, exploitation) Details of identified Risk:	Yes / No / Unknown
To Self (e.g. suicide, self harm) Details of identified Risk: When mood is low or Leon is particularly stressed he can experience an increase in suicidal thoughts and has taken numerous impulsive ODs.	Yes / No / Unknown
To Others (e.g. aggression, violence) Details of identified Risk: Potential for verbal or physical aggression when mentally unwell or under the influence of alcohol/drugs.	Yes / No / Unknown
Neglect (e.g. health, personal appearance) Details of identified Risk: When mood lowers Leon can neglect his personal care, have a reduced appetite.	Yes / No / Unknown
To Child(ren) (e.g. neglect, abuse) Details of identified Risk:	Yes / No / Unknown
Physical Impairment (e.g. medical, sensory) Details of identified Risk:	Yes / No / Unknown
Wandering & / or Falls Details of identified Risk:	Yes / No / Unknown
Memory and Cognitive Impairment (e.g. forgetfulness) Details of identified Risk:	Yes / No / Unknown
Challenges to Services (e.g. inappropriate demands, poor compliance) Details of identified Risk: In the past Leon has failed to attend appointments, shown varied compliance with his prescribed medication regime	Yes / No / Unknown
Risk Taking Potential (e.g. positive resources, agreed plans) Brief details: Leon has involvement with the CoT team and Richmond Support	Yes / No / Unknown

Patient Name: Leon Grattow CHI/Unit No. F5153833

Significant Known History (include known diagnoses & examples of risks taken):
Leon has a longstanding diagnosis of schizophrenia. When unwell especially when hearing persecutory voices, he has taken numerous impulsive overdoses. He has also experienced paranoia in the form of harbouring beliefs that people have been stealing things from his house resulting in him making calls to the police. He has when unwell made threatening calls to the police, ward two and in the past has assaulted his mother.

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

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

Sources of Information Available for this Assessment:
1) Longitric Notes from outpatients appointments and past ward admissions
2) Nursing staff with past experience of engaging with Leon
3) Leon himself in person.

In What Way Has This Assessment Taken Place?
Through analysis of psychiatric notes and past risk assessments taken.

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

Comments:

Need For More Detailed Risk Assessment & Management:

YES NO

Completed By: Andrew Anderson Date: 23/06/05

Discussed With: Time:

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

Name: LEON GRITTAN Date of Birth: 17 / 3 / 75 CHI/Unit No: FS153833

Address: 85 SPITTAL FIELD RD

INVERKEITHING Post Code: Gender MALE

Date of Assessment: 28 / 6 / 08 Time: 2330hrs Review Date: / /

Category of Risk	Assessment of Risk
From Others (e.g. abuse, exploitation)	Yes / No / Unknown
Details of identified Risk:	
To Self (e.g. suicide, self harm)	(Yes) / No / Unknown
Details of identified Risk: O.D. prior to admission. Hx of O.D's in past.	
To Others (e.g. aggression, violence)	Yes / No / Unknown
Details of identified Risk:	
Neglect (e.g. health, personal appearance)	Yes / No / Unknown
Details of identified Risk:	
To Child(ren) (e.g. neglect, abuse)	Yes / No / Unknown
Details of identified Risk:	
Physical Impairment (e.g. medical, sensory)	Yes / No / Unknown
Details of identified Risk:	
Wandering & / or Falls	Yes / No / Unknown
Details of identified Risk:	
Memory and Cognitive Impairment (e.g. forgetfulness)	Yes / No / Unknown
Details of identified Risk:	
Challenges to Services (e.g. inappropriate demands, poor compliance)	(Yes) / No / Unknown
Details of identified Risk: Poor compliance with depot/prescribed medication. Poor compliance with O/P appointments.	
Risk Taking Potential (e.g. positive resources, agreed plans)	Yes / No / Unknown
Brief details:	

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

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

.....
.....
.....
.....
.....

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

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

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

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

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.....
.....

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

.....
Comments:.....
.....
.....
.....

Need For More Detailed Risk Assessment & Management:

YES **NO**

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

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

NHS Fife

Fife Primary Care NHS Trust – Mental Health Directorate
Care Notes [CN1]

Patients/Client Name: LEON GRATTAN

Unit Number / CHI: 170375 1191 F5153833

Date of Birth: 17-3-75.

Named Nurse/Key Worker: JOAN BRAID

Date: Time:	*Multi Disciplinary Record of Important Information not held in Evaluation/Review/Variation Records etc*	Signature
8.6.08 2230hrs	Informal admission of 33yr old man. Transferred from Ward 8, QMH, for assessment. Medically fit after taking an overdose of Paracetamol @ 1130hrs this morning. Has a history of schizophrenia. Well known to psychiatric services in Dunfermline. Complaining of feeling low and depressed. Describes feeling 'black'. Had bought Paracetamol 500mg x16, went home and took the tablets. After taking the tablets Leon then panicked and telephoned Samaritans. His father contacted emergency services who took him to Q.M.H. Has had numerous admissions to Ward 2 QMH. Was last discharged from Ward 2 on 6.2.08. Prescribed depot medication but missed last injection. Has missed last outpatient appt with Dr Cavanagh (Psychiatrist).	
	- Lives alone in Inverkeithing. Is currently unemployed. In receipt of income support and D.L.A. Has 1 son with whom he is not in contact with (aged 9). Son lives with his mother. Leon was born in Manchester and brought up in Edinburgh. His Mother lives in Edinburgh but he hasn't been in contact for a few weeks. His Father lives in Manchester. He has 2 sisters whom he hasn't been in contact with for years.	
	- Denies any alcohol use. Says he occasionally smokes cannabis but denies any other drug use.	
	- Plan – informal admission to W.B.H. as no male beds in ward 2 Q.M.H. – depot due on Tuesdays – ? dose. – to be reviewed by Dr Smith. – not deemed detainable at present but to be seen if wishes to leave. –	K. Richmond S/N
9/6/08 1830	Settled in to ward well. Watched TV. Spoken to retired – slept well overnight – Still awaiting urinalysis.	J Reynolds
2.45	Leon has spent the morning between the sitting room and his bed space. He attended for lunch and has appeared settled around the ward.	
410	Richmond Fellowship phoned, will be attending the ward @ 1430 to see Leon.	K Richmond SN

Patients/Client Name: Leon Gratton

Unit/CHI Number: 7037511911 F5153833

Date: Time:	*Record of Important Information not held in Evaluation/Review/Variation etc*	Signature
9/6/08	4:00pm Richmond taking Leon out to go home for some things	Richmond
10/6/08	c/o headache tonight Given paracetamol 1g	
6:10	@ 21.40 with good effect. Stayed up	
	& watch a film sitting around 01.00hrs	
	slept for short periods overnight.	Gladwell
10.50	Phone call received from staff nurse at Ward 2 in	
	QMH stating a staff member was on way to transfer	
	Leon	
11.55	Leon was transfered from woodbank to ward 2	
	@ MH hospital, Since admission Leon has lay on	
	top of his bed, he has Since attended his lunch	SBain
12.55	Leon requested to go home to get belongings in	
	the company of his support worker, Margaret from	
	Richmond Fellowship. Due to return 3pm.	Abraham
15.10	Margaret Hamilton, Richmond Fellowship accompanied	
	Leon back to the ward. She feels he is brighter in	
	mood. Has spoken of preferring being in the	
	ward, to being at home. She feels the company	
	of others benefits him.	
	Spoke of him enjoying writing.	Abraham
	Richmond fellowship staff will visit ward 9.30 –	
	13.30hrs to see Leon, and see what he wishes to	
	do.	Abraham
20.00	Received from Lorn Richmond Fellowship advised Leon	
	was within the ward, Then asked to speak to	
	Samantha in charge. She stated was informed Leon	
	had not presented. Settled, Right interacting with	
	others/staff. Time spent within Bed Area and Multi-Rm	
	watching TV.	E.Innes
5.10pm	Re previous entry Leon was requested to undertake	
	UAs for Opiates as per procedure	
	to which immediate effect	Gratton
11/6/08	NR) Leon late to retire requesting lorazepam to aid	
07.10	sleep same denied as had received night sedation	
	spent time in dayroom before retiring around 03.00hrs.	AMASIWA
12.35	Dr Cavanaghs meeting – ~~with~~ Dr Recabarren will ~~meet~~ with	
	Leon as she has not met with him since transfer to the ward	
12.40	Dr Recabarren is meeting with Leon at the time of writing	
	will gain feed back after the meeting. Leon has been	
	Settled on the ward spending the majority in the dayroom he	
	complained of a Sore neck and arm he said he has experienced	

Patients/Client Name: Leon Learmonth

Unit/CHI Number: FS153833 / 1703751191

Date: Time:	*Record of Important Information not held in Evaluation/Review/Variation etc*	Signature
	this for long periods he said it is like a trapped nerve the Doctor was made aware	
		SBain
12.50	Feed back from Dr Recabarren Leon was expressing Suicidal idea's Dr Recabarren would like Dr Cavanagh to meet with Leon before making a decision about discharge. Dr Recabarren also looked at Leons arm. There is no concern possible trapped nerve	
		SBain
8.05pm	Leon has presented as elated and labile in mood. Socialising well with fellow clients, ~~observed~~ observed to be Laughing with fellow clients on several occasions and Singing whilst walking up ward corridor. ~~Requested unit to be enforce~~ Requested as required lorazepam medication at 1pm Same denied due to no evidence of anxiety symptoms. Also noted to be Laughing with fellow client only a few minute prior to requesting as required lorazepam	
		Slawson
8.15pm	Seen by Dr Cavanagh, no feedback given. Staff Staff to gain feedback from Dr Cavanagh	
		Slawson
2025.	At the shift change over, S/N Bain provided me with a Schedule for which Leons support workers will be visiting the Ward for support time:	
	Friday 13/06/08 10 am to 2 pm with (Sarah-Jane	
	Saturday 14/06/08 9 am to 12 pm with Gillian-Muir	
	Monday 16/06/08 2 pm to 5 pm with Gillian-Muir	
	These times have been diarised with Leon to still be made aware of the arrangements.	
		A Anderson
12/6/08	NE) Leon presenting as bright and interactive with fellow	
06:45	clients no evidence of low mood, anxiety or agitation at times appearing to laugh uncontrollably in Company of others. retired to bed and slept most around 0500hrs loud and disruptive on wakening requiring prompting not to bang doors as fellow clients were sleeping, in Dayroom early morning quite sociable and bright with others.	
		A Anderson
1010hrs	Feed back from Dr Cavanagh regarding review of Leon yesterday	
	@ To remain inpatient for further few days to allow assessment of mood and mental state	

Fife Primary Care NHS Trust – Mental Health Directorate

Care Notes - Continuation Sheet [CN1B]

Page No. 4...

Patients/Client Name: Leon Gratton

Unit/CHI Number: 7037519 T-5153833

Date: Time:	Record of Important Information not held in Evaluation/Review/Variation etc	Signature
12/16/08	Patient seen as above	
10.10hrs	To be reviewed again on Friday 13th —	Seema
12/16/08 1215	Leon has presented as bright in mood and sociable in Room. He has shown no symptoms of anxiety and yet is requesting frequently to get Lorazepam As required reduction. This has been refused as no symptoms requiring medication are evident. Dr Lacabanne to review his As required medication. —	
2005	Presentation remains unchanged from this morning. He has been bright and sociable showing no ~~[illegible]~~ symptoms of anxiety or low mood at all. He hasn't even requested any as required benzodiazepines this shift.	M. Anderson
13-6-08 0710	For long periods in the evening Leon presented very animated and laughing loudly with fellow clients. Has tried to retire to bed as other clients left dayroom, but was unable to settle. Alternated time between dayroom and bed area. Noted to be laughing to himself quite uncontrollably at these times. Staff approached Leon to discuss his presentation. Stated he is quite disturbed at present, reported his belief that he has been targetted by the "Mafia" since he was a child and that his mother wants him dead. Has had to defend himself from this threat over the years. Feels he is experiencing flashbacks of these fears. When asked how things could be improved, Leon responded by stating he could have his mood published. No explanation of the relevance of this statement was given. Stated he is feeling stressed within the ward and that he could just "end it". Given lorazepam 1mg as per border to ease anxieties, with effect.	CM Boyle
12.25	Leon up early, had words with Dr. Cavanagh - no feedback, no-one. Leon proceeded out on pass with Support Worker, returned appropriately - No problems noted —	Cpayne
1530	Received phonecall from Sarah McGuiness at Richmond wishing to know if Leon is getting passes or any plans for discharge. Said we like awaiting F/B from Dr Cavanagh. Requested to phone her on 07810000647 when we know.	S Mc
1548	Phone call to Richmond Fellowship advised Leon has passes as writes advised them shown	

Patients/Client Name: LEON GRATTON

Unit/CHI Number: 7037511911 F5153833

Date: Time:	*Record of Important Information not held in Evaluation/Review/Variation etc*	Signature
1545	MEET WD WITH LEON TO ARRANGE TIMES FOR	
cont	VISITS	
1950	Active round the Ward. He has been between his dormitory, courtyard and dayroom. He has been observed numerous times to be laughing to himself in the dormitory. He received his depot injection, Flupentixol 100mg. At the 1800hrs medication round it was noted that he had been prescribed 4mg of Flupentixol Decanoate! There was some uncertainty about wether it was supposed to be Flupentixol or Zuclopentixol tablet as in Dr. Reeabbrens notes it mentions below Commencing on Zuclopentixol / Clopixol. Dr. Gandi, duty doctor, was contacted and came to the Ward. He has prescribed 3mg Flupentixol. His once only of this which was also written up has not yet been given due to there not being any in Stock (and it was just prescribed at 2000 with the time yet to find out from other wards if they have Stock.	A. Anderson
14/6/08	Settled evening no evidence of responding to perceptual	
n/n	disturbances this evening. Leon appears to have slept well	
	overnight	P.J. Hulett
14/6/08	Leon has been out with his Richmond Fellowship	
12.15	support worker this morning. Settled morning.	AM Intosh
2000	Leon approached staff early afternoon stating he needed Lorazepam, when asked to describe his symptoms, he described psychotic symptoms and was advised that staff would consult medical staff. Leon has been prescribed Chlorpromazine 50mg for same. Leon also requested and was given PRN Paracetamol for pain on his ribcage. Leon has since been observed bright in mood and is conversing well with fellow clients and staff	P. Schuch
	Received chlorpromazine 50mg prn as per kardex.	A. Graham
14/15.6.08	Leon has not slept at all overnight despite receiving prescribed Diazepam	
NIGHT DUTY	10mg at 10pm. Bright and occasionally in mood, often observed to be giggling to himself.	K.A Kumar
15.6.08	Leon was early to rise appears settled in	
12.55	presentation, bright and reactive, spending time with peers. Requested PRN E45 cream for leg irritation.	P. Schuch

Patients/Client Name: Leon Grattow

Unit/CHI Number: F5153833 / 1703751191

Date: Time:	*Record of Important Information not held in Evaluation/Review/Variation etc*	Signature
15/6/8 2015	Leon has been active around the ward, spending time between the dormitory and courtyard. He hasn't really settled in any one place for any significant length of time. He hasn't approached staff looking for any benzodiazepines and hasn't been observed to be displaying any symptoms indicating any anxiety. He has been bright and sociable. In addition there haven't been any reported instances of Leon laughing / giggling to himself. I spoke with him in order to complete his 72 hr assessment. This didn't raise any concerns on his part: mood is fine, no suicidal ideas and no overt signs / symptoms of psychosis. Throughout he was talking freely, making sense and very appropriate.	A. Anderson
15/16.06.08	In bed from start of shift, and has slept for lengthy periods overnight.	
13.30	Leon has been settled around the ward, over familiar with staff at times ie comments. No problems.	
1400	Dr Conaghs ward round. Leon denies hearing or responding to voices, saying he is only laughing at things he has seen on television. Dr Conaugh feels Leon needs a few more days on the ward, to be reviewed for discharge later in the week.	J A
2005	On the whole settled on the ward. At time he has requested medication for anxiety without there being any evidence of his suffering any. He has accepted refusals with explanation without any protest. No evidence of any psychosis either.	H. Anderson
16/17.6.08 NIC 1500	Leon spent a settled night on the ward, appeared to interact well with other clients. Has slept for long periods.	K A Lennon
12.10	Early to rise initially. Then returned back to bed where he remains at time of report —	KMH
16.50	Telephone call received from Fiona Hunter to enquire if Leon had pass status to meet with herself and Richmond Fellowship staff at his home tomorrow at 1.30 for Richmond assessment - Informed Leon of same - P Scrutton	

Fife Primary Care NHS Trust – Mental Health Directorate

Care Notes - Continuation Sheet [CN1B]

Page No. 7

Patients/Client Name: Leon Gratton

Unit/CHI Number: F 5153833 CHI/1703751191

Date: Time:	*Record of Important Information not held in Evaluation/Review/Variation etc*	Signature
17/6/08 20.45hrs	Leon has been settled throughout shift. Approached staff asking for something for his "tremor". Spoke with Leon and advised that staff had not observed a "tremor" throughout shift. Leon then said that he was hearing his sons voice and went on to discuss his concerns about his sons safety. Chlorpromazine 50mgs given/offered and accepted at 19.05hrs with good effect.	G Hoban.
18/6/08	Continues to appear generally settled on the ward. Slept for long periods overnight.	
18/6/08 12.10hrs	Leon was up bright and early this morning. Left ward with support worker to meet with Fiona Hunter and Richmond Fellowship staff at his home. Appeared settled and bright in mood before leaving.	G Hoban
12.50	Dr Cavanagh's meeting • Awaiting feedback from Richmond • Overnight pass Thursday 19/6/08 • Weekend pass • Plan for discharge Monday 23/6/08	P. Schiavone
18/6/08 17.05	I spoke to Leon regarding overnight pass and what he planned at the weekend. He appeared surprised, shocked and quite upset at the thought, saying "I will never manage an overnight pass", spoke about his neighbour and how if he 'started' he would try to hang himself. Approached me later regarding same to say he would "top himself" if he went home overnight. Leon appears quite calm, no anxiety, mood appears euthymic even when he is telling me this. I also approached him earlier in the day for a UDS which he agreed to provide and informed me when he needed to go, however stated he could not go with staff outside the toilet.	MM Intosh
	UDS, -ve to all	MM Intosh.
	urinalysis – NAD.	
19.35	Leon has been quite settled and chatty this afternoon but appears bored and fed up.	MM Intosh

Patients/Client Name: LEON CRATTON

Unit/CHI Number: F 5153833 / 1703751191

Date: Time:	Record of Important Information not held in Evaluation/Review/Variation etc	Signature
19/6/08 06.30 N/N	Watched Football on T.V. in the company of fellow patients. then played verse cards. enjoyed a carry out meal. Requested PRN medication for agitation at 08.10 hrs and was given PRN Chlorpromazine 50mg at 0320 hrs slept soundly overnight.	L.J.
19/6/08 12.05hrs	Leon has been up early this morning. Appears bright in mood. Socialising appropriately with other patients and staff. No concerns at time of writing.	J Hobson
20.6.08	At first Leon wasn't very keen to proceed on his overnight pass which had been planned at Dr. Cranagh's team Meeting on 15/06/08. Some time later he changed his mind preceding out on pass due to return Friday 20/06/08 in order to collect further pass medication for the Weekend.	A Anderson
20/6/08	Leon returned to the ward in the early afternoon in order to collect further pass medication. he received his depot. This is next due on 27/06/08 He proceeded back on pass and is due to return on Sunday morning 22/06/08.	A. Anderson
21.6.08 06.25	Leon made several phone calls to the ward. 1st 2 were for his Dad to receive a psychiatric report. Then he phoned x2 saying he was bored. At 2pm he phoned to say he had taken to 2 days supply of Fludopenthixol ?2 x 3mg tabs for today + 1 for tomorrow Although Leon said he'd taken 18mg tabs. He was advised of his rashness of taking tabs and also taking responsibility for his actions. Said at first he'd taken them to stop voices from upstairs, then because he felt like shit, he said if he'd wanted to take a proper overdose he could have taken Paracetamol - as well. Again reminded of taking responsibility for actions. Advised to contact NHS 24.	A Anderson
1935	I Contacted Haldane House to inform them of Leon's phone calls to the Ward with the night staff. I spoke with a female there who at no point throughout the conversation said that they would or even try to, make contact with Leon to see how he was coping at home. No contact with either since this.	A. Anderson

NHS Fife

Fife Primary Care NHS Trust – Mental Health Directorate

Evaluation/Review [E1]

Patients/Client Name: Leon Grattan

Unit / CHI No. F5153833

Named Nurse/Key worker S/N Payne, S/N Anderson, N/A Callaghan

Care Plan No 1

Date: Time:	*Record of Evaluation and / or Review*	Signature
21/6/8	(1) Observation Level From time of admission Leon was been nursed at General Observations level. This has remained in place to this evaluation. This was been deemed the most appropriate level of intervention to allow staff to assess, his mood and mental state, to ensure his and others safety are preserved and to give Leon space (2) Behaviour, Social Interactions, Activity Participation At the start of admission Leon was consistently seeking out staff, complaining of distressing anxiety and therefore Lorazepam to help him cope. Often overt symptoms were absent or behaviour prior to the request being made did not tally with his reports re: his internal state. This has been consistently been fed back to Leon. He was been advised to employ other measures to aid his coping and to use medication as a last resort. There has been a marked reduction in this behaviour. Leon was often been observed to be behaving in a manner suggestive of psychosis. He isn't always distressed, has spoken with staff when finding it difficult but when the former, is less forthcoming in describing his experience. He hasn't isolated himself on the ward, or shown any difficulty in socialising. Leon has been engaging with his Richmond support workers in accordance with the documented schedule. (3) One to One Key Worker Sessions. There haven't been any problems with Leon engaging with keyworkers. These are ongoing on both a formal and informal basis. (4) Multi-disciplinary Team Meeting This has been ongoing since admission, including contact with the Community Outreach team when Leon is out on pass and with Richmond Support Workers when attending the ward.	

Patients Name Leon Gratton

Unit / CHI No F5153833

Date:	*Record* of *Evaluation* and / or *Review*	Signature
2/6/8	(5) Medication Regime – To date on the ward Leon has received his Flupenthixol depot which was not been the cause of any side-effects giving concern to him. He was also been commenced now the oral preparation of the same medication, again with no noted / reported side effects.	A. Kelly

Patients/Client Name: Leon Grattan

Unit/CHI Number: FG153833 / 1703751191

Date: Time:	*Record of Important Information not held in Evaluation/Review/Variation etc*	Signature
20/6	Leon has requested and given Lo. Procetamol 1g at 1320 and 1805 for Pain as Symptomatic relief. He has been off the ward for short periods at time machine and the Pool watching football.	J. Ch
23.6.08 0710	Enjoyed company of others, watched football. Retired & has slept well overnight.	SJ Traill
11.15	Dr Caseconsigns meeting - He spoke about Leons pass and taking tablets Leon said he was hearing voices in and outside his head he only took the tablets to make the voices stop. at present he has no Suicidal thoughts The plan for Leon this week is for him to stay on the ward today, then go on pass Tuesday, 24/6/8 until Friday 27/6/8 and attend the depot clinic at Carnegie on Thursday. a Kardex has be done and will sent to Carnegie. Richmond has been contacted regarding his passes and they will Contact Haldane House as they support him on Thursdays for his depot at Carnegie clinic. His depot injection has also been increased. Fluphentixol decanoate 100mg - to 150mg. pass medication has also been altered	SBai
12.30	Leon has been settled on the ward. spent time between courtyard and dorm, bright in manner. no problems noted.	A Graham
	Had short pass home with support worker Richmond Fellowship this morning, to visit his home.	AGraham
1.30	Leon attended the relaxation group - Objectively Leon appeared to engage well taking on board the relaxation techniques with good settling effect.	P.Schiedel
	Leon has been settled in presentation, bright in mood spent some time off the ward with staff and fellow clients, humour evident, no concerns to note.	P.Schiedel
24/6/08 0705	NR) Leon appearing settled and sociable with fellow clients, late to retire to bed getting up numerous times overnight appears to have slept fairly overnight.	A MAGIWA.
24/6/8 1015	Leon was seen by Dr Ramkumar this morning - plan is he is to go on pass until friday but return on a daily basis to collect his medication as he is on daily dispensing from	

Patients/Client Name: Leon Gratton

Unit/CHI Number: F5153833/1191

Date: Time:	*Record of Important Information not held in Evaluation/Review/Variation etc*	Signature
	his local pharmacy Leon has now left the ward on pass he is aware as is his support worker that he is to attend Carnegie clinic on thursday for his depot injection.	
25/6/08 13.30hrs	From Dr Cavanaghs Meeting: * Leon to receive his depot at Carnegie clinic ~~tomorrow~~ tomorrow * On pass till Friday * to be reviewed on Friday * No change to treatment plan.	gMcBain
26/6/08 1235.	Leon contacted the ward at ~~0830~~ this am to say he would collect his night medication of Ground Norm but has not yet attended the ward. Also contacted depot clinic to advise he had left in and missed his depot although he had phoned them at 0830 also to say he would attend. Avril Lee contacted ward to ask if he could receive his depot on ward 2 today as he ~~has~~ had been ~~able~~ to attend depot clinic.	
1605	Leon contacted the ward around 1515 asking about results about a kidney test I advised him he would need to speak with Medical staff regarding this I then asked Leon when he was returning to the ward and that he was due his depot Leon was vague about his depot but I assured him at the time I asked Leon when he was returning to the ward and he said he had an appointment with the nurse at his G.P practice at 17.40 today and ~~he~~ regarding "Problems down below" he would return to the ward after this. ~~I~~ Dr Beckham aware of this and has spoken with Dr Cavanagh if Leon does not return this evening he is to be placed on overnight pass —	
26/6/08 1900	Leon returned to the ward as planned depot not due until friday according to kardex (was only to be given today due to depot clinic) He was given his Nitrazepam as pass medication ~~due~~ and has left the ward on a further pass due to return tommorow.	

Fife Primary Care NHS Trust – Mental Health Directorate

Care Notes - Continuation Sheet [CN1B]

Patients/Client Name: Leon Gratton

Unit/CHI Number: F5153833/1191

Date: Time:	*Record of Important Information not held in Evaluation/Review/Variation etc*	Signature
1455	Leon still to return to the ward at time of writing. Informed Mr Clough to plan ab and passes to continue as agreed	
17.20	Leon received depot medication today as per Kardex. Next due to be given 3/7/08 @ depot clinic Carnegie clinic - LWFCOT informed of same & of discharge today C.P. & Richmond Fellowship also informed of discharge. Discharge Script Pend to C.P. No medication given as Leon informed staff he had Dates this and with him C.P. whilst on pass this week. Follow-up:- LWFCOT & Richmond Fellowship	Payne

Fife Primary Care NHS Trust – Mental Health Directorate

Care Notes - Continuation Sheet [CN1B]

Page No……..

Patients/Client Name

Unit/CHI Number:

Date: Time:	*Record of Important Information not held in Evaluation/Review/Variation etc*	Signature

Fife Primary Care NHS Trust
Whyteman's Brae Hospital
Kirkcaldy, KY1 2ND

NHS Fife

NURSING TRANSFER LETTER

Name: Leon Gratton
Address: 85 Spittal field Road, Inverkeithing

Consultant: Dr Smyth
Religion: ?

Tel No:

D.O.B.: 17/3/75
Unit No: F5153833
G.P.: Dr Garmony
Address: Inverkeithing Medical Practice

Next of Kin:
Address:

No.:
Relationship:

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

Informed of Transfer (Yes) / No
Diagnosis: Schizophrenia

Status: Informal

Review Date:

Transfer From: Woodbank

To: Ward 2 QMH

MENTAL STATE

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

Psychosis:-
Hallucinations
Delusions

Other:-

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

PHYSICAL STATE

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

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

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

Other:-
Specify

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

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

Self Care:- (Independant)
Requires prompting
Assist to dress/undress
Assist to bath
Uses aids - specify

Medical Condition	Skin Condition
	Good.
	Waterlow Score: 3

OBSERVATION STATUS

Special

Nurse Escort

Passes Escorted time out

RISK FACTORS

(Suicide) (Self Harm)

Absconding Wandering

Aggression - Verbal/Physical

Fire Raising Other

SPECIAL TREATMENTS

SOCIAL CIRCUMSTANCES

Unemployed.
Lives alone.
Has 9 year old son

FINANCIAL

Med 10 due 15/6
Income support
DLA

Medication	Allergies/Adverse Reactions
As per Kardex	None Known.
Depot	

Comments

Transferred from Wd 8, QMH after O.D. paracetamol 16x500mg.
Phoned Samaritans, then father contacted emergency services.
Has history of poor compliance with depot / prescribed medication

Signature RL 2 Date 10/6/08

(CONSENT TO SHARING INFO.

Fife Primary Care NHS Trust – Mental Health Directorate

Care Notes - Continuation Sheet [CN1B]

Page No.....

Patients/Client Name: Joan Grattin.

Unit/CHI Number:

Date: Time:	*Record of Important Information not held in Evaluation/Review/Variation etc*	Signature
12/4/05	No-one to receive information.	WHT Tarbosh

Fife Primary Care NHS Trust – Mental Health Directorate

Care Notes - Continuation Sheet [CN1B]

Page No……..

Unit/CHI Number;

Patients/Client Name

Date: Time:	*Record of Important Information not held in Evaluation/Review/Variation etc*	Signature

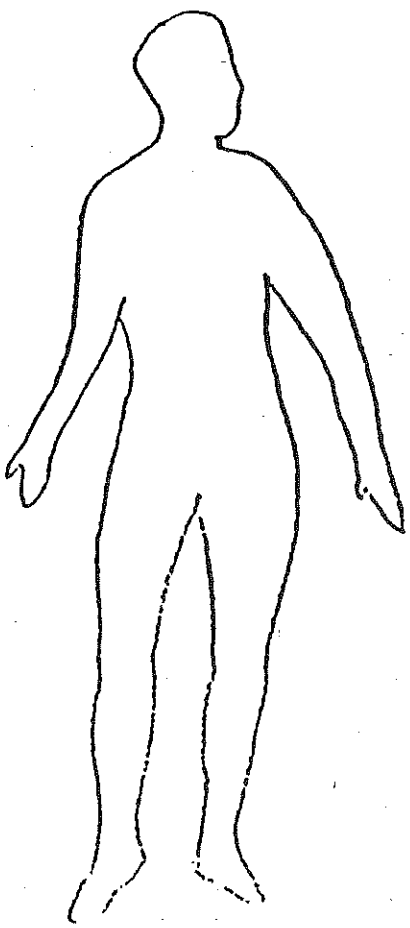
WATERLOW ADMISSION SCORE : 3

REASSESSMENT :			
DATE	SCORE	NURSE'S SIGNATURE	COMMENTS
8·6·08	3	A. Ward	On admission

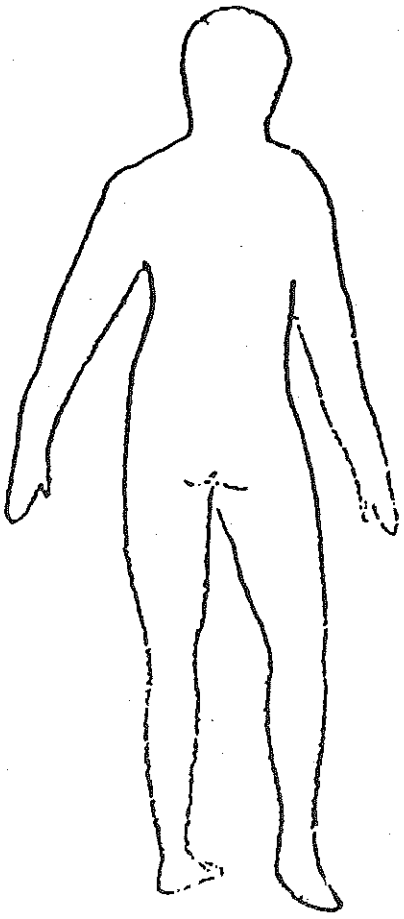
MS491

LEON GRATTAN

Front



Back



WATERLOW SCORE

10+ At Risk

Build/Weight for Height	
Average	0
Above Average	1
Obese	2
Below Average	3

Continence	
Continent	0
Catheterised	1
Occasional Incontinence	1
Catheterised but incontinent of faeces	2
Doubly incontinent	3

15+ High Risk

Skin Type Visual Risk Area	
Healthy	0
Dry	1
Tissue Paper	1
Oedematous	1
Clammy (Temp)	1
Discoloured	2
Broken	3

Sex / Age	
Male	1
Female	2
14-49	1
50-64	2
65-74	3
75-80	4
81+	5

Mobility	
Fully	0
Restless	1
Apathetic	2
Restricted	3
Inter	4
Traction	4
Chairbound	5

Appetite	
Average	0
Poor	1
Fluids only	2
NG Tube	2
Nil by Mouth /	3
Anorexic	3

20+ Very High Risk

Special Risks	
Tissue Malnutrition	
Terminal Cachexia	8
Cardiac Failure	5
Peripheral Vascular Disease	5
Anaemia	2
Smoking	1

Neurological	
C.V.A.	
Motor/Sensory Paraplegia	4-6
Diabetes	
Multiple Sclerosis	

Major Surgery Trauma	
Orthopaedic / Below Waist Spinal	5
On Table > 2 Hours	5

Medication	
Anti-inflammatory	
Cytotoxics	4
High Dose Steriods	

Care Pathways

Fife Primary Care NHS Trust - Mental Health Directorate

Acute Inpatient - Admission to Hospital [F1]

NHS Fife

Ward /Dept WHYTEMANS BRAE - WOODBANK WARD

Name: LEON GRATTAN		Care Plan Number 1
C.H.I. Number	Unit Number F5153833	Date Commenced 8.6.08
Consultant/G.P. DR SMITH	Prescribed By Named Nurse: JOAN BRAID	Date Resolved

Description of Need:

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

Objective/Expected Outcome

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

Actual Outcome

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

Acute Inpatient - Admission to Hospital [F1]

Patient/Client Name_____ Unit/CHI No _____

ACTION TO BE TAKEN: - **CARE PLAN – Admission to Acute Ward**	Date	Signature
1. Implement observation level as prescribed by multidisciplinary team in accordance with Trust /hospital policy and procedure.		
2. Observe client's behaviour, social interactions and participation in activities.	2.6.08	K. Yland
3. One to one patient interactions enable collection of information on the client's mental state and the problems that they perceive.		
4. Liaise with members of the multidisciplinary team regarding client's mental/physical status.		
5. Administer medication as prescribed.		
6. Report and record all observations and any information gained from patients interaction accurately		
7 Liaise with carers and relatives to gain a comprehensive profile of presenting problems		
8. *Individual Nursing Actions Required: -*		
Monitor K.D.L's	2.6.08	K. Yland

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

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

.....

Fife Primary Care Division - Mental Health Directorate

Episodes of Care Sheet A1-EC

Patients Name ..... LEON GRATTAN ..... Unit/CHI No .....

Episodes of Care: Page .....

Area	Referred by	Reason for Referral	Admission / Contact Date	Named Nurse	Discharge/ Transfer date	Outcome/ Discharges to
WOODBANK WARD WHYTEMANS BRAE	Q.M.H.	O.D. this am. Low mood Suicidal Ideation.	8.6.08	JOHN BEKALD		

...e Primary Care Division - Mental Health Directorate

Episodes of Care Sheet A1-EC

Patients Name .....

Unit/CHI No .....

Episodes of Care: Page .....

Area	Referred by	Reason for Referral	Admission / Contact Date	Named Nurse	Discharge/ Transfer date	Outcome/ Discharges to

NHS Fife – Mental Health

ADMISSION ASSESSMENT / HISTORY TAKING [A1-1b Elderly]

NHS Fife

Patients Name ... Leon Gratton ... 1703751191 Unit/CHI No ... FS153833

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

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

Came on ward himself, mother aware in wards

9 Nursing observation of patient's mental state

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

Agreeing to being in hospital, to try to get out of cycle of taking drugs (speed).

10 Nursing observation of patient physical state

Temperature 35·8 Pulse 79 Blood Pressure 132/65

Urinalysis NAD. Skin State Eczema/psoriasis Glasses No Hearing Aid No

Dentures Yes Dentures Marked: Yes ☐ No ☒

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

General Appearance Unshaven, casually dressed.

Distinguishing features

Height 1.86 Weight 72kg Build Medium Eye Colour Blue

Hair colour Short brown Shoe Size 11 Posture Upright

12 Physical problems experienced at home/previous care setting

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

Weight loss over 6 weeks. Approx 2–3 stones

13 Self Care problems experienced at home/previous care setting

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

Reduced self care over past 6 weeks.

14 Communication problems experienced at home/previous care setting

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

No problems reported.

15 Confusion problems experienced at home/previous care setting

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

No problems reported.

Patients Name Leon Gratton Unit No 1703751191 F5153833

16 Behaviour experienced (problems) at home/previous care setting
(including: persistent walking indoors and/or outdoors, repetitive behaviour, resistance to being cared for, episodes of verbal and/or physical aggression)

None reported

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

None reported.

18 Emotional problems experienced at home/previous care setting

Low in mood.

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

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

2009 QMH.