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

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

1/11/03
2pm

RL

At ease, pleasant. Dressed in pyjamas.
° Evidence hypervigilance / responding to hallucinations
And EC, ° abnormal movements.
S: ② rate & intonation
M: O: euthymic, reactive
S: "fed up" "depressed" of these voices? poor sleep appetite ↔
no ongoing suicidal intent:
P Describes hearing "music" at night Voices - people talking - no clear description
and "noises" — like the "roars of a jail" absence
C Orientated TPP.
D Wishes a ↑ clopixol depot
∴ has worked "to a degree" but doesn't feel
he is on enough medication

Took overdose of meletonin ∴ he wanted a few days sleep
but also "wanted to die" — despite praying mother afterwards.
Has been feeling paranoid" since taking cannabis from
his neighbour last week. "I never learn"
Also had an argument in mum before admission
"I keep dredging up the past" — she feels bad - I feel bad
- It's my fault"

HL
(Hx 2340)

Imp Delirium in MS — 2° to cannabis use
Dysthymia in mood although does not present as depressed/flat

Plan Continue to monitor mood & MS. ↑ Depot to clopixol 2/52 weekly
Continue to review in hosp grounds only.

MS873

1/12/02 WR Dr Cavanagh

c/o NH shouted voices - only some recognisable; comes from outside his head. directed at him, swearing, nasty comments, general chit-chat. used no longer has idea of reference from TV - attributes this to cannabis use.

used "alright" conflict ? cause sleeping with Dan ward

Plan

Enforce day-night routine.
Continue to assess nds on ward.
Continue escorted passes.
Stop lorazepam PRN, continue haloperidol PRN, due depot. depixol 25mg weekly

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

8/12/03

No sleep last night, c/o "racing thoughts".
lorazepam PRN discontinued yesterday
aripiprazole has hx of no effect

Plan

temazepan 20mg nocte
haloperidol 5mg PRN

Abbother visiting regularly
Leon has been less suitable (aggressive) with her

Unescorted passes with hosp grounds.

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

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

5/12/03

Rh

Quite settled overall. Mum visits daily. No MX problems
Appears relaxed, undistressed.
No sign of agitation.
Slept well last night. Wants temazepam discontinued ?
need to resume ? "Melatonin doesn't work"
S ⓓ rate & intonation
in O: ... reactive
B: "OK"
getting on better with mum, "trying to forget the past"
hasn't felt annoyed / angry c her for past few days
T ?FTD, no delusional / paranoid content elicited.
? ideas of reference from radio
P Heard voices last night - people "roaring"
from a distance.
C Orientated TPP.
I Hopes he will continue to improve and be d/c
soon ? next week.
Happy to stay in hosp.
Adhering to passes within hosp grounds

Imp
WS improving
COT - please contact ? escorted home for several
hours at w/e.
Unescorted passes within hosp. grounds [signature] CHO/SHO

MS873

8/12/03 WR Dr Cavanagh

Little sleep on Sat night - V. irritable & argt c mum on Sun
Slept well last night. - no AH in bed last night.
Admits to irritability c mum yesterday - phoned to apologise

No AH during the day.
No evidence of FTD
Plan to stay in pt for ~ 2 wks longer until MS much better
Passes next w/e to see son (short day passes) as long as
MS continues to improve after mid week - none at present.
Cl ?pipothiazine 15mg nocte.
Not detainable. [signature]

10/12/03

Noted irritability in the morning
Later in afternoon, brightens & becomes warmer in affect & interaction
OT to engage.
PRN haloperidol used c good effect, less frequently.
Has slept well for last 3 nights
D/c next week?
Passes as wishes. [signature]

11/12/03

Asking for O/N pass Sat → Sun
O/E Pleasant, warm affect
mood O & S euthymic
°FTD nil delusional sleeping OK
Denies any further nocturnal AH
States his mum agrees c his decision to go home O/N for his son's visit this w/e. Son normally stays with [?]'s mum when he visits. Plan O/N pass. Notify COT. [signature]

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

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

15/12/03

Rv c Dr Canavagh

Returned from o/n pass yesterday

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

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

Responding verbally to Television last night

Paranoid ideas about "people after him/controlling him"

Believed his ex-wife was upstairs in his house c a neighbor

Under his pass most well

Denies ideas of reference from the TV

Admits to slight irritability

Sleeping well

Plan

Add in oral anti-psychotic. — Haloperidol 2mg qid

Rv over next few days

Dr Canavagh will arrange to meet c mum with Leon's consent.

MS873

16/12/13

RW

Up till 3am last night. – ? chatting ? daughter pt.

Also up during the night – ? hearing people talking – ? AH

feeling a bit low

? angry ? mum – "she has her own agenda" "wants to control my life"
"she likes to torture me" "I've asked her not to visit – she's mean to me too!"
admits to wanting to punch her, but knows better than to do that
"? I'll end up in jail!"

Says he still has the samurai swords at home
– he was collecting them for interest
writing a book about ninjas
doesn't plan to use them
"Why do you ask?"
Explained that I had to ask him ? if his supressed aggressive
thoughts towards his mum.

Wonders about O/N pass at w/e

Plan

RW later this week – Fri

No O/N passes at present.

Short unescorted passes in hosp. grounds only.
? psychotic SX ? exceed authority to mum.

Explained passes to him ? that I will RW him later this week – OK with this.

(HPISHO)

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

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

16/12/03

Wants to go home for o/n pass this week -
Tired of being on the ward
feels people are making fun of him
- could state any specific incidents
Denies any intent to harm his mum -
Swords are for collection only
Denies any Att presently except for
? hypnagogic Att last night.
Not detainable
Accepts advice to stay in-pt.
Agrees to o/n pass on Thurs - back for RV Friday
and Sun night : son is visiting
Discuss Dr Cavanagh

(HO 8th)

17/12/08

Rlv of plan

O/N pass Thu – Fri and Sun – Mon

Slept OK last night

Contin meds as per kardex ← slept clopixol 250mg weekly
← risperidal oral reg.

Not detainable

[signature]

19/12/08

Uneventful pass

Denies any auditory hallucinatios

Slept OK – woke up ~ 3am but not distressed about this

Also met mum last night – got on OK

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

Would be OK to go on w/e pass Fri to Mon for r/v

[signature]

(HO/SHO)

NAME Leon Gratton	Continuation Sheet No.	Unit No.

D.O.B 17/3/75

GP: DR TAYLOR
INVERKEITHING MEDICAL CENTRE

Consultant: DR Cavanagh

CPN: tom sho

11/3/07

P.C: Over dose

Background: - Schizophrenia
- Borderline personality dis.
- Known to psych. team.
- Previous admiss. in to W2
- On Depixol weekly depot.

HoPI:

Presented to A&E with h/o overdose of Loratidine ~ 250 mg in total ~ 10 tablets this afternoon.
Claims he heard voices asked him to commit suicide and die (told you) "ITs not worth living" you'd better off dead".
- Responded to these sounds, shouted at them with (F) word.
- Pt now claims that he is "sick of living".
- Semi impulsive act. No planning.
- planned to take his life any.
- Fed up with life.
- Didn't leave any suicidal notes or will.
- Not planned. Semi impulsive responding to the voices.
- Neighbours were laughing at him (as he thinks).
- took paracetamol as well 8-10 tablets.
- phoned OHS 24 → Send him an ambulance. → A&E
- Claims that he was trying to take the rest of the tablets - doesn't know why he didn't take them.
- Still has the thought of killing + harming him self.
- Doesn't regret it, wish he'd done it and he thinks he would die anyway.
- Not hearing voices at the moment.
- No trigger tonight. (but sick of living is general)
- Still have intention to die but " he hope not as he thinks he cannot control it.
- missed your depot x2 over the past 2 weeks as he was sleeping all day.

- Sleep 12hrs day sleepy is very interrupted over night.
- Very poor appetite.
- Good concentration + energy.
- His grandmother died 5 weeks ago - affected him badly
- phones W2 for ability retrieve (talks to staff).
- Denies taking any drugs tonight / or any alcohol
- Have paranoid ideas about people (thinks people broke into his house and broke few stuff.)

Psych Hx: On Depot Clopixol weekly depot
- NITRAZEPAM at night.
- Diagnosed as schizo affective / personality disorder (borderline).
- Known to our psych services.
- Under DR Cavanagh last seen him 2 months ago.
- Seen Dr. Lehany. Haldane house. → 2 weeks back. reduced Depot dose.

Medical Hx: Eczema.
Asthema.

Social Hx:
- lives alone for the past 5 years
- Bottom flat (Correct)
- Unemployed.
- Incapacity DLA Benefits.
- Smoker 40/day.
- occasional drinks.

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

Personal Hx:
- Born in manchester.
- Primary + Secondary school (Edinburgh)
- Never been to uni.
- No qualifications.
- Been brought few jobs.
- Worked as labourer 7 years back.
- Now unemployed.

NAME Leon Grafton	Continuation Sheet No. 1.	Unit No.

D.o.B 17/3/75

Mental State examination

A: Casually dressed. average built.
average self care.

B: odd behaviour, paranoid looking through the window from time to time.
- Responded to voice once but conduct understood what he said.
- Co operative.
- Good eye contact.
- Good communication.

T: Still having thought of suicide / self harm.
- NOFTD.

M: Very low. Affect: restricted at times reactive at time.

P: Sees black and white people in the room. Speak to him and disappear after a sudden.

S: Normal speech (tone, Rate, volume)

C: Intact.

Insight: poor insight.

phys: Examination.
- o Odour o Jaundice o pallor.
- No distressed or in pain.

chest: clear good AE both sides

Abdomen: soft
- o Masses
- o Rebound
- o Guarding
- o Rigidity

Neurology: Cranial nerves (N)
Cerebellar signs (N)
No visual problems

Pupils equal in size + reactive to light

- Power / sensation / tone all N
- Reflexes Not done.
- Coordination (N) Gait (N) Speech (N)
- Fundoscopy → Not done.

(P) - Needs admission to Rothes ward.
- Eventually found a bed (last bed) in Rothes ward.
- Kardex
- Physical exam.
- DNW Rothes
- SHO informed — tried to phone again → bleeped → Couldn't get through.

- Paracetamol 0.18 (below Rxline.)
- Salicylate < 0.2
- U+E : Na 138
  K 3.9
  Ur. 3.7
  Cr. 87
  Albumin 46
- LFTs - Not back till tomorrow
- ECG → Normal
- Medically cleared by SHO

T. Mukherjee
SHO
2296

T. Mukherjee
SHO
2296

NAME Leon Gratton	Continuation Sheet No.	Unit No.

1-2/3/10

Review Dr Barron –

Felt that everything was getting on top of him'
Called @ 10hr 24 himself.
Feels that he may damage his liver by taking op and didn't want this to happen.
Feels that someone is coming into his house and taking things. Thinks it may be his neighbours. 'To wind him up' as he was a ~~pre~~ drug user previously.
Missed his last 2 depots as he was spending all the time texting a girl called 'Susan'. ~~Felt asleep~~
Slept 7:4 late in the day and so missed his depot.
Is not taking anymore as he ~~has~~ he reduced a 30ml for £300 for his phone.
Was previously on Cr dopram, not on it now.
Has taken overdoses in the past, usually in times of stress. Usually once every 3 months.
Calls Samaritans almost every night.
Afraid he would wake up and find his throat slit by old enemies because he knows secrets about them, so they consider him a threat.
Relationship ~ parents 'up and down'.
Parents split up. Dad in Manchester. Gets on well ~ him.
Lives alone. Flat. Does not like being alone.
Living like this for 5yrs
Lived in Airdrie Homeless Accomodation 5yrs ago
At the time he was in a relationship ~ lasted 3-4yrs. They broke up and she kicked him out. Was assaulted in the Homeless Hostel.
Before that he was in Penumbra in sheltered Accomodation.
~~Does~~ Denies any excessive alcohol use or any illicit

Drug use.
Sees support worker twice a week.
Sees CPN once a week.
Redmond comes in 4 times a week.
finds weekends and nights the most difficult.
Sees Dr. Cavanagh every 3 months.
Last admission 2 yrs ago.
Does not feel that his dept help.
Would like something to stop hallucinations.
Hears someone talking in his ear at least once or twice a day - sometimes good, sometimes bad that talks to him.
Sees things - people appearing and disappearing in his room - black and white, not clear, sometimes if the day in his house.
Paranoia - feels everyone is out to get him and are laughing at him. Cannot be sure if this is true.
Thinks people do laugh at him because he is an 'idiot', as he hasn't achieved anything worthwhile.
Has one son 5 yrs ago who lives in his mum. sees him twice a month. Son is slightly depressed.

Plan -> To obtain a medical note from Dr Fernelius.
Observation, continue assessment.

12/3/07 Interviewed in absence of notes, from last year of
Longstanding psychosocial issues
self esteem poor "feel like village idiot"
"picked on" Vulnerable
Maladaptive coping strategy of overdosing
— OD's 2 every 3/12.

NAME ~~[illegible]~~ | Continuation Sheet No. | Unit No.

12/3/07 ~~[illegible]~~ Leon [illegible]

Not overtly psychotic
Not overtly depressed, not actively suicidal
Feels lonely in single occupancy accommodation, Here x 5 yrs

Lost Leppy in [illegible]

Lots of community supports

Missed depot x 2/52
as texting girl, all loss of [illegible]
got bill on Sunday - £500

Plan:
Does not appear to be any acute
issues
Resume medications
Here c Leon

[signature]
[illegible]

13/3/07
Medical records still not arrived
Left message for Dr Connolly to
get in touch [illegible] 12/3/07 [signature]

14/3/07 SG review –

Received dept Today.
Has generally been feeling better. Mood much brighter.
Has been observed to singing, humming to herself.
Still believes that people are laughing at him, ~~in~~ in fact
woke up last night thinking that he heard others in the
room laughing at him. Now he is not sure if this was
a dream.
Sleep still not as good.
Appetite good. Eating well. Pleasant & appropriate at interview
Denies any continuing thoughts of self harm.
Notes still awaited.
PCon -> Caitlin was present

EJ SG.

15/3/07 CPA Dr. Barlow –

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

Interview –

Appears brighter.
Says he has felt dizzy at times.
Explained to him that his problems are long standing. No
need for us
Can agree to this
Happy to have gotten his depot.
Sees his CPN once a week. on a Friday.
Explained to him that being in hospital is not beneficial
and would be better to discharge him.
Can agree to this.
Is going to a party tonight organised by his mum.

NAME Leon Gratton. | Continuation Sheet No. | Unit No.

15/3/07 Plan) No D/C meds as he has them at home.
F/U by CPN Tom Short, to information of Leon's discharge.
To inform his mother of D/C.
To be given Nitrazepam for tonight.
D/C today.

15/3/07

Spoke to Dr Cavanagh
agrees long standing issues
agreeable to discharge
No evidence of acute psychopathology

Spoke to Leon's mum on phone
Discussed the situation
She agrees also with discharge

Discharge Today
to be given one night's meds only
to help of the risk of OD [illegible]

Nursing staff to inform Tom Short of
D/C + ? review ~~tomorrow~~

MS878

Surname	
First Names	Lean
Maiden Surname	
Address	Gratton 17/03/75

Unit No.	
Date seen or Admitted	
Seen at	
Seen by	
Consultant in Charge	
Family Dr.	
Referred by	

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

01/04/08 4PM.

patient brought up by WFCOT for assessment

Dx Schizophrenia
emotionally unstable personality disorder borderline type.

WCFOT Attended home to administer depot.
concerns raised by team over weekend, patient reported
two 8 co-codamol tablets. Was advised to attend
A+E at that time, however did not.
When visited by team today was c/o dizziness +
command suicide hallucinations; last night took 8
further co-codamol
Compliant w depot.
Team cannot identify any stressors leading to
presentation.

Seen→
"I've not slept all night"
"voices, hallucinations you name it"
Ongoing for 3-4 months, ↑ volume + intensity in ~~last~~ 05/01/08
"window got smashed"

Answer who or why this was done
"Voices, overdose, paranoia"

Voices → "get back to your own space"
"wouldn't touch you with a bleeding barge pole"
2nd person derogatory, one more common but worse.
"I think it actually happening"

Voices occur "just after an overdose" when "tired of stressed out"

Took overdose on Saturday 12 co-codamol, "sick of living"
No preplanned, no note. precipitated by "loneliness"
Argument with mother + father precipitated; "not had a partner for 7 years" Called Richmond fellowship, told Community outreach team "fine"

Took 8 tablets "Dad called me a piece of dirt"
Tuesday, 8 co-codamol, ~~did not tell~~ called samaritans
"cause I called the samaritans 'I'm not depressed'"

Last OD last night, 8 paracetamol, took all in one go 2 at a time, every 2 hours; same today.
so essentially 4 every 2 hours. "Intention of dying"
Although no current suicidal ideation or plan, would not do anything because of children.
"very relationship between me and my father"

"paranoia" →
voices make him "paranoid", once able this is, wants to hear them. Voices how, vague.

Mood "low" 3/10., sleep → 3-4 hours a night, "years", appetite, normal activity, not for "years", memory poor "years", concentration good-energy levels → poor last 2/52. Enjoyment → neglects.

Surname	Unit No.
First Names Leon	Date seen or Admitted
Maiden Surname Grafton	Seen at
Address 17/03/15	Seen by
	Consultant in Charge
	Family Dr.
	Referred by

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

past ψhx

Under CUFOT. Long ψhx, poorly under child & services.
on depot. Last self harm, after Grandmother death 1 year ago.
Dx schizophrenia at 18, IPCU in past.

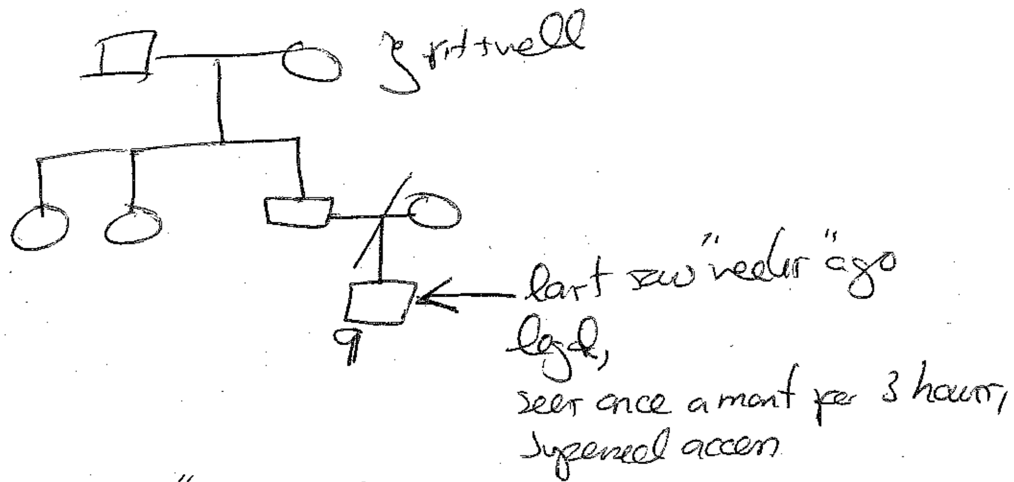
medical hx

none

medication

flupentixol 50mg weekly
diazepam 10mg OD mane
nitrazepam 10mg nocte → agreed with CUFOT

family hx



Aunts suffer from "? agoraphobia"

Drugs + EtOH

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

Forensic hx

Hit mother + her partner, "few yrs now" → domestic → no charges pressed. Denies convictions.
Due to be inappropriate with female staff ? disinhibition in past

MS873

Past Hx

Issues of abuse as child as documented
Discussed with patent, does not wish to revisit childhood
Born in Manchester, bright up in Fife, aged 15 mother revealed himself + his sister has been sexually abused by father, which led to estrangement with mother. Care homes 15-16 w/ drug use.

Current Social

Living in house, council, living alone. No friends or family nearby. Debt of €10,000. No current relationship.
Unemployed

MSE A+B → Caucasian gentleman, casually dressed, good rapport, good EC, carrying book of his poetry and a pen.

S → (N) rate, rhythm + volume

M → "O" [illegible]
"S" low, 3/10

T → Vague paranoid ideation 2° to hallucinations, although not of psychotic intensity currently, more concerns.
No current suicidal ideation but states if given chance likely will act against himself again
∘ T I/W/B ∘ passive ∘ FTD
no homicidal ideation or plans

P → 2nd personal auditory hallucination, patient has insight that these are "voices" but are "real", derogatory + command suicide. Visual → flashes of light → insight changes period

C → full

I → unsure nature of problem, denied triggers, willing for admission for short term assessment.

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

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

Leon
Gratten
17/03/75.

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

o/e sitting in chair, in no distress
BP 126/82, P 72 bpm regular, T 36.2°C
CVS I + II + 0 murmurs
Abdo soft non-tender BS (N)
resp good A/E bilaterally
no creps or wheezes
neuro - grossly intact

invest of paracetamol OD
bloods for FBC, U+E, LFT, coag, paracetamol, salicylates, bicarb.

(P) Ask on call Dr to chase bloods;
admit informally;
general obs
PRN rapid tranq.

(SHO)

2/2/8
2PM

SHO ON CALL FOR PSYCHIATRY

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

MS873

04/02/08 W/. Dr Cavanagh

"Ulcer"
Dergatory.
hx of overdoses revisited,
sleep poor, slept well in hospital
"not as depressed, not lonely"
Argument with father on Friday.
Mother visited yesterday, "raging all the time"
phone mother after overdose last week
"Been hallucinating alot" → "cars screaming into people"
"lasers running."
phoning samaritans rather than mother at night →
mother became annoyed, feels unsupported

Discuss T depot.
(P) T flupentixol ~~60mg~~ 40mg 1/52.
↓ diazepam 6mg

05/02/07 4/52

reviewed at Dr Cavanagh

Hx revisited;
explored events leading up to admission, 2/52 ago difficulties with girl he became friendly with, son in her shop was abusive towards him and asked him not to return. He has not seen this woman since.
Arguements with father.
patient discounts these events rather difficulties w/ neighbour; swastika painted on wall near flat seen this related to him, disagreements with gangs in Edinburgh.
Ongoing concern of neighbour upstairs, although ongoing for 2 years, no change
Neighbour threatening towards him, claims he is a drug dealer and has dispute with him in particular. Although persecutory, clear, not delusional, no associated psychotic symptoms with these concerns. Would not act against neighbour.

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

Leon Gratton.

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

More settled in hospital, no voices since admission.
Mood much improved, sleeping well.
laughing and joking.
Can have suicidal ideation, no plan. This is a chronic feature for 7 years related to lack of relationship although has interest in his writing, attempting to get published and engaging in WFCOT groups
Denies illicit drug use, adamant would not do drugs good insight into this.
Concept via law, no homicidal ideation towards others despite interpersonal difficulties. Although chronic suicidal ideation no intent to act and hope for the future.
Patient D/w Dr Cavanagh → given permission to D/w mother

(P) D/C tomorrow
↑ WFCOT support
OPD rdy
talk therapy w/ abuse issues

[signature]
(SHO)

MS873

wd 2

FIFE PRIMARY CARE

Referral to: HILLVIEW DAY HOSPITAL **Date:** 21.2.02.

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

ADDRESS : 85 SPITTALFIELD ROAD

INVERKEITHING

TEL NO : (416833) → 07762602059 - 420856 Mr Gratton
07762994266.

G.P. Dr. GARMANY **CONSULTANT** Dr EDWARDS

REASON FOR REFERRAL: **Routine** ☑ **Urgent** ☐

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

Referral for assessment - ? Anxiety management, ? Men's group

SOCIAL CIRCUMSTANCES:

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

~~1st app. 12/3/02.~~

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

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

Present medication Olanzopine 10mg, Imstral.
? compliance.

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

Discussed between Lesley Tweedie **Referrer.** Mike Kelly **Recipient**

Appointment date and time

PE meeting 25/2/02 ✓

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	~~12/3/17~~	~~12/3/17~~		~~LORATIDINE~~								
B	12/3/17			RANITIDINE	150MG	OML	✓		✓			
C	12/3/17			NITRAZEPAM	10MG	OML				✓		
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	12/3/17			LORAZEPAM	1-2MG	OML/IM	AGITATION	8MG/24°	
S	12/3/17			HALOPERIDOL	2-5MG	OML/IM	AGITATION	18MG IM/24° or 30MG OML/24°	
T	12/3/17			PROCYCLIDINE	5MG	OML	EPSE	15MG/24°	
U	12/3/17			SYMPTOMATIC RELIEF POLICY					
W	12/3/17			LORATIDINE	10MG	ORAL	ALLERGY	10MG/24°	
X									
Y									
Z									

	START DATE	DISCONTINUED Date	DISCONTINUED Signature	DEPOT INJECTIONS	DOSE	FREQUENCY	PRESCRIBER'S SIGNATURE
1	~~12/3/07~~	14/3/07		~~ZUCLOPENTHIXOL DECANOATE~~	~~300mg~~	~~weekly~~	
2						~~IM Tuesday~~	
3	14/3/07			FLUPENTIXOL DECANOATE	300mg	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

NAME OF PATIENT [redacted] | AGE [redacted] | DATE OF BIRTH [redacted] | UNIT No. | CONSULTANT [redacted] | WARD ROTTIES

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
11/5/7																		3	KR							(R) DUE 18/5/7
17/5/7																		3	KR							(L) DUE 25/5/7
26/5/7																		3	DS							(R) 1/6/7
31/5/7																		(3)	KR							
1/6/07																		3	AR							(L) due 7.6.07
8/6/07																		3	DS							(R) 15-6-7
15/6/7																		3	DS							(L) 22-6-7
25/6/07																		3	CM							(R) Due 1/6/07
5/7/07																		4	AR							(L) due 12-7-07
12/7/07																		4	AR							(A) due 19-7-07
19/7/07																		4	AR							(L) due 26-7-07
26/7/7																		4	KR							(R) DUE 2/8/7.
3/8/7																		4	KR							(L) DUE 9/8/7.
10/8/7																		4	KR							(R) DUE 17/8/7

NAME: Leon Gratton UNIT No: DOB 17/3/75 WARD: COT

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
8/3/04																		Ⓐ	CH							CF 13/3/04
13/3/7																		Ⓐ	KR							CF-715/3/7 letter sent
20/3/07																		3	TS							due Ⓐ 27/3/07
27/3/07																		Ⓐ	DS							CF 29/3/04
29/3/07																		Ⓐ	CH							CF 3/4/04
30/3/07																		Ⓐ	TS							C/F 3/4/07
3/4/07																		3	CH							Ⓛ due 10/4/04
10/4/04																		Ⓐ	DS							C-F 12-4-07 letter sent
12/4/07																		Ⓐ	CH							CF 14.4.04
17/4/07																		3	AK							C/F 19.4.04
19/4/04																		Ⓐ	DS							C-F 26-4-07 letter sent
24/4/07																		Ⓐ	TS							home VISIT
25/4/07																		3	TS							due 1
24/5/07																		3	DS							due 1/5/07 Ⓛ

NAME: Lean Ofratton UNIT No: WARD:

(MP) 57

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	12/3/07			LORAZEPAM	2mg	P.O	Agitation	6mg / 24hr	
S	12/3/07			LORAZEPAM	2mg	I.M	Agitation	6mg / 24hr	
T	12/3/07			HALOPERIDOL	5mg	P.O	Agitation	15mg / 24hr	
U	12/3/07			HALOPERIDOL	5mg	I.M	Agitation	15mg 24hr	
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 Leon Grafton | AGE 21 | DATE OF BIRTH 12/3/7- | UNIT No. | CONSULTANT | 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

	REGULAR PRESCRIPTIONS																		DEPOT INJECTION		AS REQUIRED						COMMENTS ON DISCREPANCIES
Date	8.00	Intls	13.00	Intls	18.00	Intls	22.00	Intls	OTHER TIMES Code	Time	Intls	Code	Time	Intls	Code	Time	Intls		Code	Intls	Code	Time	Intls	Code	Time	Intls	
12/3/07					B	ND	C 2	GS													UA	13.30	AI				UA - 20ml
13/3/07	B 2	I.m			B 2	DT	C 2	GS													Ug R	12.35 20.30	VS ND				Ug. 12.35 1gram paracetamol VS.
14/3/07	B	MMc			B 2	DT	C [illegible]	[illegible]											3 (L)	AI	V	0045	GS				Ug = 1gr.
15/3/07	B	SC			(B)	VS																					

NAME: Leon Gratton UNIT No: WARD: Rothes

(MR) 57

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
6/6/06																		1	(L)							* couldn't stay attend today due 20/6/06
29/6/06																		1	due							(L) due Next Due 4-7-06
4/7/06																		(A)	due							CF to 6-7-06
5/7/06																		1	(L)							(R) due 20/7/06
1/8/6																		1	KR							(L) DUE 1/8/6
1/8/6																		(A)	CH							CF 8/8/06
1/8/6																		1	CH							(R) Due 15/8/06
15/8/6																		(A)	KR							Letter sent >17/8/6
17/8/06																		(A)	CH							CF 22/8/06
17/8/06																		1	R							(L) due 31-8-06
28/8/06																		1	T							R due 12/9/06
12/9/06																		1	D							(L)
24/9/06																		1	T							(R) 9/10/06
9/10/06																		1	T							(L) due 23/10/06

NAME: LEON GRATTAN UNIT No: WARD: CAT

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
23/10/06																		1	AL							Due 6-11-06
6/11/06																		1	TS							(R) due 20/11/06
20/11/06																		1	TS							(L) due 4/12/06
4/12/06																		2	DS							(R) Due 18/12/06
13/12/6																		2	KR							(L) DUE 27/12/6
18/12/06																		2	TS							(L) due 28/12/06
4/1/07																		2	TS							(R) due 18/1/07
18/1/07																		(A)	TS							C/F 23/1/07
23/1/07																		2	AL							(L) due 6.2.07
1/2/07																		2	AL GN							(R) Due 8/2/07
11/2/07																		2	TS							Due 16/2/07.
21/2/07																		3	PJ							(R) 1/3/07
1/3/07																		(A)	TS							C/F 6/3/07
6/3/07																		(A)	AL							CF 8-3-07

NAME: Kean Cavatten UNIT No: WARD:

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	9/4/16			HALOPERIDOL 5mg x (5)					Reg
S	9/4/16			NITRAZEPAM 5mg x (5)					Reg
T									
U									
W									
X									
Y									
Z									

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

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

ONCE ONLY MEDICINES AND PREMEDICATION

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

NAME OF PATIENT [illegible] | AGE 71 | DATE OF BIRTH 17/1/[illegible] | UNIT No. [illegible] | CONSULTANT | WARD

PRESCRIPTION SHEET (USE BLOCK LETTERS)

Sheet No. 2

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

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

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

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

ONCE ONLY MEDICINES AND PREMEDICATION

DATE	MEDICINE	DOSE	METHOD OF ADMINISTRATION	TIME	PRESCRIBER'S SIGNATURE	GIVEN BY	GIVEN AT
17-12-03	Haloperidol	2mg	Oral	18:40	[illegible]	[illegible]	18:45
17-12-03	Haloperidol	2mg	Oral	18:40	[illegible]	CR	21:35
17-12-03	Zopiclone	15mg	Oral	18:40	[illegible]	CR	21:35
18-12-03	Haloperidol	2mg	oral	09:15	[illegible]	SE CL	09:15

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

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	5/12/03	6/12/03	[illegible]	MELATONIN	4mg	ORAL				✓		[illegible]
B	5/12/03	5/12/03	[illegible]	TEMAZEPAM	10mg	ORAL				✓		[illegible]
C	5/12/03			ZOPICLONE	7.5mg	oral				✓		[illegible]
D	5/12/03			Haloperidol	2mg	ORAL	✓	✓	✓	✓		[illegible]
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	28/11/03			SYMPTOMATIC RELIEF POLICY.					[illegible]
S	28/11/03			HALOPERIDOL	5mg	ORAL	AGITATION	4 hourly; max 15mg	[illegible]
T	28/11/03			HALOPERIDOL	2.5mg	IM	AGITATION	4 hourly; max 10mg	[illegible]
U	28/11/03	1/12/03	[illegible]	LORAZEPAM	2mg	ORAL	AGITATION	12 hourly; max 4mg	[illegible]
W	28/11/03			LORAZEPAM	2mg	IM	AGITATION	12 hourly; max 4mg	[illegible]
X	3/12/03			Dipro-Base Cream	1app	topical	dry skin	PRN BD	[illegible]
Y									
Z									

	START DATE	DISCONTINUED Date	DISCONTINUED Signature	DEPOT INJECTIONS	DOSE	FREQUENCY	PRESCRIBER'S SIGNATURE
1	28/11/03			Zuclopenthixol Decanoate CLOPIXOL	250mg	weekly (Mon)	[illegible]
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
02/12/03	ZOPICLONE	7.5mg	ORAL	23.00	[illegible]	[illegible]	23.00

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

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	41413			zopiclone	7.5mg	oral	insomnia	x 1 in 24hrs	JSmith.
S									
T									
U									
W									
X									
Y									
Z									

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

ONCE ONLY MEDICINES AND PREMEDICATION

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

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

NAME OF PATIENT | AGE | DATE OF BIRTH | UNIT No. [redacted]

CONSULTANT | WARD 2

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
4/4/03																				R X4 issued TG TO WF COT						

NAME: LEON GRATTAN UNIT No: ..... WARD: 2

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

PRESCRIPTION SHEET No.

KEY
Ⓐ DRUG REFUSED
Ⓐ PATIENT ABSENT

FIFE HEALTH BOARD
MEDICINE RECORDING SHEET

Date	REGULAR PRESCRIPTIONS 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
3/11/05																		2	TS							Ⓡ due 10/11/05
10/11/05																		Ⓐ	F							forward 15.11.05
15/11/05																		2	TS							24.11.05 (TWH)
24/11/05																		Ⓐ	CM							C/F 29/11/05
25/11/05																		2	TS							due 1-12-05
1/12/05																		Ⓐ	TS							C/F 6-12-05
7/12/05																		2	TS							due 15/12/05
15/12/05																		Ⓐ	CM							C/F 20/12/05.
20/12/05																		2	DML							Ⓡ Sick Nurse. Due 29-12-05
30/12/05																		2	TS							Ⓒ due 5-1-06
4/1/06																		2	TS							due 15-1-06
14/1/06																		2	TS							due 21-1-06 Ⓛ
21/1/06																		2	TS							Ⓔ due 28/1/06
27/1/06																		2	TS							Ⓛ due 3-2-06

NAME: LEON GRATTAN 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

FIFE HEALTH BOARD
MEDICINE RECORDING SHEET

	REGULAR PRESCRIPTIONS											OTHER TIMES						DEPOT INJECTION		AS REQUIRED						COMMENTS ON DISCREPANCIES
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	
25/7/05																		2	AL							(L) Stde.
1/8/5																		2	KR							(R)
9/8/5																		(A)	KR							
11/8/05																		2	KR							(R)
18/8/05																		2	CM							(L)
25/8/5																		2	KR							(R)
2/9/05																		2	TJ							(L)
8/9/05																		2	TJ							R
21/9/05																		2	TJ							(L)
29/9/05																		2	RH							(R)
6/10/5																		(A)	KR							
13/10/5																		2	KR							(L)
20/10/5																		2	KR							(R)
24/10/05																		(A)	CM							FORWARDED TO 31/11/05

NAME: Leon Gratton UNIT No: .... WARD: COT

FHB/MRL 57

PRESCRIPTION SHEET IS CHANGED
PRESCRIPTION SHEET No.

KEY
G REFUSED
ENT 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
27/3/05.					EMERGENCY SUPPLIES		MEDICATION 6x R.	AR QMN																		

NAME: LEON GRATTEN UNIT No: WARD: 2

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												

SIX DOSES AS OUTPATIENT MEDS.

	START DATE	DISCONTINUED Date	DISCONTINUED Signature	AS REQUIRED MEDICINES	DOSE	METHOD OF ADMINISTRATION	INDICATION	MAXIMUM FREQUENCY	PRESCRIBER'S SIGNATURE
R	22/3/5.			ORPHENADRINE	PO	50mg.	EPSE	UP TO TDS	B Vaughan
S									
T									
U									
W									
X									
Y									
Z									

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

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

ONCE ONLY MEDICINES AND PREMEDICATION

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

NAME OF PATIENT [redacted] AGE DATE OF BIRTH 12/8/44 UNIT No. [redacted] CONSULTANT 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
11/12/03							C	~~PEI JO.~~ JJ																		
12/12/03							C	JJ												PA R	0515 1100	Rubk SRK				
13/12/03			PASS MEDICATION CHECKED & SUPPLIED TILL 14/12/03			MP LP	~~C~~ CR																			
14/12/03							C	CR JO																		
15/12/03			D	RL DM	D	LT / TG	~~C~~ C D	CR / JJ										1	LT / TG							Depot given Depot next due 22/12/03.
16/12/03	D	LR BS	D	KL CS	D	SC DM	C D	CR / JJ												Rg	13.00	KL CS				
17/12/03	D	SC RL	D	LT RL																						(D) As once only
18/12/03	(D)	SE CL	Pass meds supplied until & inc 19th 12 03		0800	SD SE																				
19/12/03			D	DJ CL	D	TG KL	PASS Med supplied until 22-12-03	SE KL																		
22.12.03			D	SE SD														1	SE SD							(R) Side, next due on 29-12-03.

NAME: LEON GRATTON UNIT No: F515 38 33 WARD: TWO

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
27/11/03							(A)																			
28/11/03																										
29/11/03							(A)		A	23:00										S S T	9:30 21:35 21:35					
30/11/03									A	23:00										S M S	15:00 22:00		T	22:00		
1/12/03									A	23:00								1	PH. SE	S W X	17: 19:00 16:00		S W	21:55 21:55		DEPOT GIVEN (L) Side NXT DUE 8/12/03
02/12/03									A	23:00										S	21:55					
03/12/03							(A) B													S X S	02:40 13:00 17:00		X	20:30		
4/12/03							(A) B																			(A) Refused
5/12/03							(A)	C																		
6/12/03								C												X	22:00					
7/12/03								C												X	04:00					
08/12/03								C										1	SE							Depot given R Side next due on 15/12/03
9/12/03								C																		
10/12/03								C																		

NAME: CONGLATON UNIT No: WARD: 2

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

PRESCRIPTION SHEET No.

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(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
1/9/03																		4	UK							L side n. cr 8/9/03
8/9/03																		4	JH							(L) SIDE
15/9/03																		4	JH							(R) SIDE
22/9/03																		4	JH							(L) SIDE.
29/9/03																		4	JH							(R) SIDE
6/10/03																		4	JH							(L) SIDE.
12/10/03																		4	JH							(R) SIDE
20/10/03																		4	JH							(L) SIDE
27/10/03																		4	JH							(R) SIDE
~~4/11/03~~																										(L) SIDE
4/11/03																		4	JH							⇩
10/11/03																		4	JH							(R) SIDE
17/11/03																		4	UK							(L)
24/11/03																		4	LS							12

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

IMP\57

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
5/4/04							ERROR	JH										~~1~~	JH							
31/1/05																		2	VW							(R)
7/2/05																		2	JH							
22/2/05																		2	JH							
1/3/05																		2	JH							
7/3/05																		2	JH							
~~14~~ 3/05																		2	CM							(R)
~~5/4~~/05																		2	CM							(L)
18/4/05																		2	TS							(L)
9/5/05																		2	TS							(C)
16/5/05																		2	TS							(R)
24/5/05																		2	CM							(L)
30/5/05																		2	TD							(R)

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

(MR) 57

PRESCRIPTION SHEET (USE BLOCK LETTERS)

Sheet No.

	START DATE	DISCONTINUED Date	DISCONTINUED Signature	REGULAR MEDICINES	DOSE	METHOD OF ADMINISTRATION	0800		1300		1800		2200	Other times	PRESCRIBER'S SIGNATURE
A	17.3.02	18.3	M. Nv	~~Olanzapine~~	15mg	O							✓		M. Nevs
B	17.3.02			Lustral / Sertraline	50mg	O	✓								
C	18.3.02	21.3.02	M. Nv	~~Olanzapine~~	15mg	O							✓		M. Nv
D	21.3.02	25.3.02	M. Nv	~~Olanzapine~~	5mg	O							✓		M. Neal
E	27.3.02	29/3/02	[illegible]	Haloperidol	2mg	O	✓			MN	✓		✓		M. Nau
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	17.3.02			Zopiclone	7.5mg	O	Insomnia	Nocte	M. Nv
S	17.3.02			Haloperidol	5mg	O	Agitation, as required upto T.D.S		M. Nv
T	17.3.02			Lorazepam	1-2mg	O	Agitation, as required upto 4mg in 24 hours		M. Nv
U	20/3/2			Procyclidine	5mg	O	EPSE	daily [illegible]	[illegible]
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
17.3.02	Clopixol Decanoate	100mg	I.M.		M. Nv	[illegible]	12⁰⁰ hrs.
1/04/02	CLOPIXOL DECANOATE	100	IM		[illegible]	PH [illegible]	17-10
18/04/02							

NAME OF PATIENT: Leon [illegible] Greville | AGE | DATE OF BIRTH | UNIT No. [illegible] | CONSULTANT | 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	Code	Time	Intls	OTHER TIMES Code	Time	Intls	Code	Time	Intls	DEPOT INJECTION Code	Intls	AS REQUIRED Code	Time	Intls	Code	Time	Intls	COMMENTS ON DISCREPANCIES
2/4/02																				0025 / 0025 / T	T / R / 18.10	R / RB	T / R	2215 / 2215	LR / LR	(NP) [illegible] mg.
3/4/02	A	M. SD SN			Pass meds supplied [illegible] inc of 8am. inc of [illegible] [illegible]			RS												T	1425	SD SN				
8/4/02					Pass meds supplied [illegible] until 12/4 [illegible] inc of 8am.			RS																		
10/4/02																				(T) / R / (T)	18.00 / 22.00 / 22.00	[illegible]				(T) 1mg only 18.00 (T) 1mg only 22.00
11/4/02	A	[illegible]																		(T)	1740	SD				(T): 1mg given 1740
12/4/02	A	RS			PASS MEDS. INCLUSIVE of 8am 15/04/02 [illegible]			RS																		
					PASS MEDS INCLUSIVE of 8am 22/04/02			RS																		

NAME: LEON [illegible] UNIT No: S065370M WARD: 2

(MR) 57

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PRESCRIPTION SHEET No.

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Ⓐ PATIENT ABSENT

MEDICINE RECORDING SHEET

Date	REGULAR PRESCRIPTIONS 8.00	Intls	13.00	Intls	18.00	Intls	22.00	Intls	OTHER TIMES Code	Time	Intls	Code	Time	Intls	Code	Time	Intls	DEPOT INJECTION Code	Intls	AS REQUIRED Code	Time	Intls	Code	Time	Intls	COMMENTS ON DISCREPANCIES
17/3/02	B	[illegible]																		T S R	03.25 16.15 23.00	[illegible]				
18/03/02	B	PH					C	[illegible]												S T	0025 0025	[illegible]				
19/03/02	B	[illegible]					C	[illegible]												T	2230	[illegible]				
20/3/02	B	[illegible]					C	[illegible]												T R	14.50 2205	[illegible]				
21/3/02	B	[illegible]					D	[illegible]												T S T	0025 0340 0000	[illegible]				Gaviscon 10mls at 0155hrs [illegible] Gaviscon 10mls @ 03.55
22/3/02	B	[illegible]					D	[illegible]												(T)	17.00	[illegible]				(T) 1mg accepted.
23/03/02	B	[illegible]					D	[illegible]												(T)	1715	[illegible]				(T) 1mg Lorazepam at 17.15
24/3/02	B	[illegible]					D	[illegible]												S T	1715 1715	[illegible]				(T) 1mg lorazepam
25/3/02	B	[illegible]																		T.	21.40	[illegible]				
26/3/02	B	[illegible]																		T R	0245 22.20	[illegible]				
27/3/02	B E	[illegible]					E	[illegible]												T T	0025 22.00	[illegible]				
28/3/02	B E	[illegible]			E	[illegible]	E	[illegible]												S T T	1135 1900 2240	[illegible]				T 1mg Lorazepam T 1mg Lorazepam
29/3/02	B E	[illegible]																		T	0100	[illegible]				T 1mg at 01.00
1/4/02																				(T)	2210	[illegible]				(T) 1mg only -

NAME: LEON GRATTAN UNIT No: J065370M WARD: 2

(MR) 57

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	11/12/21			DIAZEPAM	2mg	ORAL	ANXIETY.	4 HOURLY	
S									
T									
U									
W									
X									
Y									
Z									

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

TICK IF PRESCRIBED ON THE FOLLOWING SHEET ✓

LIST OF MEDICINES TO BE AVOIDED DUE TO PREVIOUS REACTION

MEDICINE	REFERRED DATE

ONCE ONLY MEDICINES AND PREMEDICATION

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

NAME OF PATIENT [illegible] | AGE | DATE OF BIRTH | UNIT No. | CONSULTANT | WARD

PRESCRIPTION SHEET (USE BLOCK LETTERS)

Sheet No.

	START DATE	DISCONTINUED Date	DISCONTINUED Signature	REGULAR MEDICINES	DOSE	METHOD OF ADMINISTRATION	0800		1300		1800		2200	Other times	PRESCRIBER'S SIGNATURE
A	2-4-02			Seclealine	50 mg	O	✓								M. [illegible]
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	2-4-02			Zopiclone	7.5 mg	O	Insomnia	Nocte	[illegible]
S	2-4-02			Haloperidol	5 mg	O	Agitation aggr.	TDS	M. [illegible]
T	2-4-02			Lorazepam	1-2 mg	O	Agitation aggr.	upto 4mg in 24 hours	[illegible]
U	2-4-02			Procyclidine	5 mg	O	EPSE	TDS	SD M. [illegible]
W									
X									
Y									
Z									

	START DATE	DISCONTINUED Date	DISCONTINUED Signature	DEPOT INJECTIONS	DOSE	FREQUENCY	PRESCRIBER'S SIGNATURE
1	~~10/4/12~~			~~Clopixol~~	~~150mg~~		
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
2-4-02	Seclealine	50mg	O	Stat	M. [illegible]	AS SE	11.30
10/4/12	CLOPIXOL DECANOATE.	150mg	IM	19.20	S Sen[illegible]	SE VS	15.20

NAME OF PATIENT: Lean Geatle | AGE | DATE OF BIRTH | UNIT No. [illegible] | Dr [illegible] CONSULTANT | WARD

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PRESCRIPTION SHEET No.

KEY
Ⓐ DRUG REFUSED
Ⓐ PATIENT ABSENT

MEDICINE RECORDING SHEET

	REGULAR PRESCRIPTIONS																	DEPOT INJECTION		AS REQUIRED						
									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	COMMENTS ON DISCREPANCIES
11/12/01					Rx 14 Pt Pass UP Mxs	Surrended Meds, follow via	CPN	✓ CM																		

NAME: Leon Grattan UNIT No: .... WARD: 2

INTERIM DISCHARGE AND PRESCRIPTION FORM

Queen Margaret Hospital

Whitefield Road, Dunfermline, Fife, KY12 0SU

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

Dear Doctor

Your Patient

Address
(including Post Code)

Date of Birth

was admitted to hospital under the care of.....in ward.....

and is now being discharged/transferred to .....

Reason for Admission

Principal Diagnosis
Main Condition

Other Conditions
and/or complications -
to include external causes

1.
2.
3.
4.
5.

Operations/
Procedures

1.
2.

A discharge letter will follow

Comments.....

.....

.....

Arrangements for review.....

The following medicines are recommended:-

MEDICINE FORM AND STRENGTH	DOSE	DIRECTIONS FOR ADMINISTRATION	RECOMMENDED DURATION OF TREATMENT	QUANTITY SUPPLIED

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

Name in Capitals .....

Designation Consultant ❑ Clinical Assistant ❑ Registrar ❑

Senior House Officer ❑ House Officer ❑

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

Dispensed By: .....

Pharmacist: .....

Date: .....

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

MS501/12/95

INTERIM DISCHARGE AND PRESCRIPTION FORM

Queen Margaret Hospital

Whitefield Road, Dunfermline, Fife, KY12 0SU

DATE OF ADMISSION	/ /
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Main Condition

Other Conditions and/or complications - to include external causes

1.
2.
3.
4.
5.

Operations/ Procedures

1.
2.

A discharge letter will follow

Comments .....

.....

.....

Arrangements for review .....

The following medicines are recommended:-

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

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Senior House Officer ☐ House Officer ☐

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1st White Copy - General Practitioner
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3rd Yellow Copy - Patient's Records

MS501/12/95

Bayer

MULTISTIX* 10 SG REPORT

Name LEON GRAHAM Date 17-3-02

Ward 2 Patient No. _____

Tf Please tick appropriate box for each test

LEUCOCYTES 1 to 2 minutes	NEG.	TRACE	SMALL +	MODERATE ++	LARGE +++		
NITRITE 60 seconds	NEG.	POSITIVE (any degree of pink colour)					
UROBILINOGEN 60 seconds	3 Normal	16	µmol/l	33	66	131	
PROTEIN 60 seconds	NEG. g/L	TRACE	0.30 +	1 ++	3 +++	≥ 20 ++++	
pH 60 seconds	5.0	6.0	6.5	7.0	7.5	8.0	8.5
BLOOD 60 seconds	NEG.	NON HAEMOLYZED TRACE	HAEMOLYZED TRACE	SMALL +	MODERATE ++	LARGE +++	
SPECIFIC GRAVITY 45 seconds	1.000	1.005	1.010	1.015	1.020	1.025	1.030
K[illegible]E 4[illegible]ds	NEG. mmol/L	TRACE 0.5	SMALL 1.5	MODERATE 4	8	LARGE 16	
BILIRUBIN 30 seconds	NEG.	SMALL +	MODERATE ++	LARGE +++			
GLUCOSE 30 seconds	NEG. mmol/L	5.5 TRACE	14 +	28 ++	55 +++	≥111 ++++	

*Trademark of Bayer Corporation, USA.

X600264 mpl

NURSING PROFILE

WARD 2 QUEEN MARGARET HOSPITAL

DATE OF ADMISSION: 17 MARCH 2002

CONSULTANT: Dr EDWARDS

PATIENTS NAME: LEON JAMES GRATTAN

KEYWORKER: ALISON GRAHAM SCOTT ELVIN

ADDRESS: 85 SPITTALFIELD ROAD INVERKEITHING

NEXT OF KIN: Mrs LORNA GRATTAN

ADDRESS: 42 SPITTALFIELD ROAD

TEL NO: 01383 416833

RELIGION: NONE SPECIFIC

TEL NO: 01383 420856 07762 602112.

MARITAL STATUS: SINGLE

WORK TEL NO:

D.O.B: 17.3.75 **AGE:** 27

RELATIONSHIP MOTHER

UNIT NO S0655370-

GP & ADDRESS Dr GARMORY INVERKEITHING H.C.

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

REASON FOR REFERRAL:

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

SOCIAL CIRCUMSTANCES

LUCE OF OWN HAS TWO SISTERS EMMA AND JOANNE WHO ARE VERY SUPPORTIVE. HIS PARENTS LIVE AROUND THE CORNER FROM HIM AND ARE ALSO VERY SUPPORTIVE, LIVED WITH GIRLFRIEND SHE IS SOCIAL WORKER, HAVE ONE SON TOGETHER SPLIT UP → LIVING ALONE NOW, RECENTLY PHONED EX-PARTNERS BOSS AT SW DEPT IN AIRDRIE MAKING ACCUSATIONS, CHARGED BY POLICE FOR SAME.

PAST PSYCHIATRIC HISTORY:

Known to services due to paranoid psychosis.
Attends Hillview day centre once every two weeks ?
Additional info - Sectioned Royal Ed ? When, admitted to monkLands Hospital from oct 2000 - Jan 2001 ⇒ speaking in german accent → (weight ↓ to 5 stone)

MOOD LEVEL

Objectively low — Rated mood on Scale of 1-10. (8)
Subjectively low — Same agreed.

CLIENTS INSIGHT:

limited insight happy to stay in the ward for safety

SUICIDAL IDEATION:

None voiced

MEMORY:

ST — States no problems
LT -

ANXIETY SYMPTOMS:

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

BEHAVIOURAL PROBLEMS:

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

DRUG/ALCOHOL DEPENDENCE:

Denies any illicit drug or alcohol misuse
Smokes cigarettes
Additional information has used Cannabis from age of 13yrs, also LSD, Speed (claims) minimum alcohol intake denies using any illicit drugs lately.

ESTABLISHING INTERACTIONS:

limited rapport building regarding presentation.

THOUGHT DISORDER:

Paranoid belief that someone is trying to kill him by gas poisoning
Experiences both auditory and visual hallucinations
At time of assessment Leon responding to visual hallucinations stating someone threw a spark into room, sparks in day room, has to pace up and down to keep Viens from collapsing

COMMUNICATION:

Closed body position head down no eye contact, Voice low and soft. Interview suspended because 'Leon found it too difficult due to hearing Voices

PAST MEDICAL HISTORY

EATING AND DRINKING

Dietary intake reduced regarding loss of apetite.

ELIMINATING

Claims no problems in this area.

SLEEPING PATTERN

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

PERSONAL CLEANSING /DRESSING

MOBILITY No problems

ALLERGIES

None Known.

URINALYSIS N.E.D

OBSERVATIONS: T. P. R. B.P.

ANY OTHER PHYSICAL PROBLEMS

Limited infomation.

SOCIAL WORKER: Ann Watson

C.P.N. Leslie Tweedie

HEALTH VISITOR

AGENCIES/SUPPORT ON ADMISSION

Hillview Day Hospital, Not complying.

EMPLOYMENT/ BENEFITS

INSURANCE LINE

DATE ISSUED	NEXT DUE

HOBBIES AND INTERESTS

GENERAL DESCRIPTION

HEIGHT	WEIGHT	BUILD	EYES	HAIR	SPECTACLES	DENTURES
6FT	13ST 4LB	Slim.		Brown Short.	NO	NO

DISTINGUISHING FEATURES

ANY OTHER IMPORTANT INFORMATION

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

DATE	Leon Gratton NURSING NOTES – Continuation
17/3/02	Leon was referred to the unit for assessment by the emergency SP.
N/D	His mental state has deteriorated due to non compliance of medication over
03[30] hrs	the past week. Leon has become increasingly paranoid believing that his house is poisoned by carbon dioxide and it is about to "blow". Leon had turned on his water taps to stop the risk of fire from the gas leak. Gas board have found no evidence of a gas leak but have turned the gas off. Leon found it difficult to complete initial admission assessment due to tiredness mainly. The remainder of admission to be completed tomorrow. Leon's body language was closed with little or no eye contact during admission interview. He did ~~not~~ appear agitated and requested PRN Lorazepam 2mg at 03:25hrs with good effect and quickly settled into bed and was seen asleep.
	Plan of care
	Admit informally
	Place on 15 minutes observations initially to be reviewed tomorrow
	Medication as per drug kardex
	Assess mood and mental state
	P Hubbard
1230	Leon remained in bed for the majority of the AM despite regular encouragement from staff to rise. Ate well to lunch. Dr Nerney yet to undertake physical examination and will do so in early PM. Dr Nerney also amended Kardex to allow test dose of depot to be administered today. Dose of Zuclopenthixol Decanoate 100 mg. yet to be given. DM Boag
1400hrs	Phone call received from Leon G.P. asking if we could contact her, to let her know where Leon is. Used Leon permission to phone his mother, Same granted by Leon. Mother contacted and made aware of Leon admission to ward. Staffing
1550hrs	Phone call received from Leon mother: MRS Gratton. She has visited Leon's house. Leon has flooded his spare room as he had called out tradesmen at 2100hrs last night and they cut off his supply, due to his fears of a leak. She described Leon's house as like a "tip" with dirty cutlery and crockery in every room. Staffing
1620hrs	From Dr Nerney physical done, no problems noted. Refused test dose of depot medication. To remain on 15 minute timed interventions at present. Blood to be done am'd (FBC, U&E, thyroid function test and liver function test). Given P.R.N Haloperidol 5mg @ 16:15 hours. Has increased agitation with good effect. Remains quiet and settled in presentation, observations maintained

@ 15 minute intervals. P Humble

17/18.3.02 N/D Leon noted to be laughing to unknown stimuli and appeared to ~~be~~ be pacing the corridor quickly. Leon stated that he was experiencing difficulty getting off to sleep. He was offered and accepted Zopiclone 7.5mg at 23³⁰ hours with no effect. He continued to respond by laughing to unknown stimuli. Leon was offered and accepted Haloperidol 5mg and Lorazepam 2mg at 00.25 hours with good effect. He settled to sleep at 01³⁰ hours and remains asleep at time of report. Leon remains in general observations of 15 minute hourly interventions.
P Humble

1200 hrs Feedback from Leslie Tweedie as she had met with Leon this ~~am~~ Suggests that Leon panicked at home. Still to be reviewed by Dr Edwards continue with assessment on ward at present. Leon still pacing a little this ~~am~~ Late to rise out of bed encouraged by staff to eat / drink to which same agreed. V A

2000 Leon this evening still appears agitated, has spent time in dayroom but reluctant to speak to others. Visited by relatives this evening, with them at time of writing. Leon still occasionally pacing up and down ward. Eddie

18/9.3.02 N/R Reasonably settled on presentation. Retired around 11pm and has slept well. K A Lumsden

AM ENCOURAGED ON MANY OCCASIONS TO RISE THIS AM EVENTUALLY DOING SO AROUND 11AM. REMAINS DISTRACTED AND PREOCCUPIED AT TIMES. HOWEVER PLEASANT ON APPROACH – BLOODS TO BE TAKEN FOR FBC, UEE's, LFT & TFT. 1ST ATTEMPT UNSUCCESSFUL AND LEON TOO ANXIOUS FOR 2ND ATTEMPT AGREED TO THIS BEING DONE IN PM. AM

pm. Spoke with Leon (I've been visiting alternate week to L. Tweedie) Leon seems to remember incident surrounding admission. Still V. angry with his ex-partner (Liz Grattan) and not being able to see his son. Ann Watson

2030 Leon spent some time between bed area and dayroom. Due to ward environment bloods were not done but Leon is agreeable for same to be done in AM. Requested to meet with medical staff re medication and when he may be discharged. Due to the time being

DATE	LEON CRAWFORD — NURSING NOTES – Continuation
	after his regular Dr had left, Leon stated he could wait until tomorrow for the relief. D.H.Kay
19/20.3.02 OK	Appeared unsettled during the late evening; restless and pacing. When approached by staff, spoke of leaving, anxious to get home and clean up the mess he'd made. Said that he had been feeling paranoid and had thrown a bar of water around. Requested to meet with staff to discuss blocks having been and results. Expressed concern about his rent collapsing earlier today. Required some reassurance although continued to appear aggravated. Offered and accepted prn lorazepam 2mg at 22.30 hrs with good effect. Slept well overnight. L.A.Lumsden
11.25am	Late to rise this morning. Does not appear to have attended to personal needs yet. Continues to present as pre-occupied and distracted at times. Reactant on approach from Staff. Attending to personal needs at time of writing notes. S.Gardner
P.M.	Leon approached staff requesting that his house be checked for a methane gas leak. S/N Thom met with Leon and reminded him that he had called the Transco emergency gas team out who had checked for gas leaks and had disconnected his supply. Leon says he is sure his house was filling with gas and heating up. Leon said these thoughts had been getting worse recently. Offered and accepted PRN Lorazepam 2mg at 14.50 hrs with good effect. Settled in the evening and socialised with the patients. — A. Rea
20/21.3.02 NJR	Leon appeared restless and unsettled overnight. Given prn lorazepam 2mg at 00.25 hrs with little effect. Noted to be laughing and talking to himself whilst lying in bed. Offered and accepted prn haloperidol 5mg at 03.40 hrs eventually settling to sleep at 06.00 hrs. Leon has missed garrison 10 mls on two occasions for hiccups and indigestion brought on by a cheese take-away. L.A.Lumsden
AM	CLINICAL MEETING - EXPRESSING NO PARANOID IDEATION - WANTS TO GET A JOB - BUT HAS BEEN SAYING THIS

DATE	LEEDS GRADUATES	NURSING NOTES – Continuation
		TO ITHS C.P.N. L. TWEEDIE FOR 6 MONTHS BUT LACKS MOTIVATION TO DO ANYTHING ABOUT THIS - CLAIMS TO BE ALLOWED – NO SUICIDAL IDEATION OR PLANS - TO HAVE TEST DOSE OF DEPOT TODAY - TO ATTEND ITHS CLINIC WHILST ON WARD - CLOZAPINE REDUCED apk
cont.		TEST DOSE DEPOT GIVEN APPOINTMENT MADE TO ATTEND ITHS CLINIC FOR INTRODUCTORY GROUP NEXT WED AM. apk
pm		been generally settled during afternoon, had a bath and attended to personal needs assisting staff to tidy bed area. approached staff this evening requesting information as to when he would be discharged advised medical staff would be consulted re same, also would like pass out tomorrow to buy birthday present for his mother. P. Hunter
21/22.03.02		Spent the evening wandering between bed area and dayroom, difficulty settling, offered and accepted as required Lorazepam 2mg at midnight, with some effect, eventually settled and slept from a.a.o. Prior to retiring was complaining of a tingling sensation in his arms, which he says has been present for a few days. J Clark
22.3.02 am		been requesting pass this morning, advised that medical staff have stipulated escorted passes only, advised that this would be assessed during afternoon if staff are able to accompany him. P. Hunter
22-3-02 pm.		been has been settled this afternoon/evening, spending time between dayroom and bed area. Visited Asda accompanied by Mother to buy b.thday present returning appreciately Scott Ellis
23.3.02		NR Spent evening between dayroom and bed area, slept for long periods overnight A Ford
23.3.02 am		been requesting to be prescribed 'E 45' cream for dry skin. Plans to go on pass this afternoon into town with his mother. P Hunter
(pm)		Approached Staff appearing tense, anxious and preoccupied, unable to elaborate on thought process. Given Diazepam 1mg

23/3/02 (Fri) at 17.15hrs with a good effect. More settled as evening progressed, although still appearing pre-occupied at times. Spent a short time off the ward, in the company of his mother at start of shift, returning appropriately. Slept

8.20pm Leon requested to know when he would be discharged. Spoke with Leon, voiced paranoid and suspicious thoughts regarding other being nice to his face, but talking about him behind his back. Also spoke about people being able to "dampen his thoughts and his ex-girlfriend, being out to hurt him by getting back at him. Given support and reassurance that staff would not allow anything to happen to him. Slept

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

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

24-3-02 Weekend Summary
- Difficult to rise in mornings despite prompting.
- Agitated at times, using Lorazepam 2mg with good effect.
- Appears tolerant of test dose of depot, no side effects noted.
- Returning appropriately from day passes, escorted at present
- Still has occasional paranoid and suspicious thoughts
- Mostly settled in mood, occasional anxiety / paranoia.
- Keen to know plans for his discharge. ———— Staff RG

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

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

DATE	LEON GRATTAN NURSING NOTES — Continuation
25.3.02	Settled during evening after receiving 10pm medications early. Spending short spells in dayroom. Retired early to bed & has slept well overnight. E. Black.
25-3-02	Leon has been spending time at bed area and occasional time in dayroom w/ others - pleasant in manner on approach but says he is a bit disturbed by thoughts in his head. He is concerned about his flat and wishes to see doctors to discuss his discharge plans. Intends to see Dr Nensey this afternoon if possible. Staff Nurse
Pm	Dr Edwards Meeting: • Discontinue Olanzapine • To have pass from Thurs - Mon • Depot on Mon. - discharge if pass goes well. • Reported O.G. crisis to Dr Edwards - not recorded in Nursing Notes - prescribed Procyclidine 5mg PRN. P Shapter
26.3.02	Restless & pacing a lot during evening. Requested & given P.R.N. Lorazepam 2mgs @ 21.40hrs. This had no effect & Leon continued to be restless although pleasant in mood. Requested that I read a "horror story" which he is writing. I did so & content is quite "violent & gorey". Unable to settle for any length of time. Offered & accepted further P.R.N. Lorazepam 2mgs @ 02.45 hrs. Retired to bed & has slept soundly from 03.00 hrs. E. Black.
am	Appears more settled this morning. Conversing with staff when approached. Appears brighter and more relaxed in presentation. J. Mulligan
12.15pm	Leon's mother arrived on ward with clothes and cigarettes when asked if she would like to see Leon she replied "Am I Hell" Concerned over phone calls Leon has been making to her house and wishes staff if possible to monitor these. Mrs Grattan was clearly distressed stating "you ask him what he said to me" I will not have my life put at risk has requested Staff to leave a message for L. Tweedie as she has tried to contact her on numerous occasions with no success. When message passed on to Leon he stated it is all about the grandchild and that it is his child and not his mothers. He then stated "I take it she is still not talking to me" J. Mulligan

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DATE	Leon Gratton NURSING NOTES – Continuation
In	Discussed telephone calls and content of same with Dr. Edwards. Dr Edwards has advised that Mrs Gratton should inform the police if feeling threatened by Leon. Rhapd Leon is to be reviewed on Fri at 3pm by Dr. Edwards, depending upon outcome Leon may proceed on pass as arranged or for a short period. Rhapd.
PM	Settled evening, no episodes reported Capt
27.3.02	Spending time in dayroom during evening. Requested sleep Zopiclone 7.5mgs. to help him sleep. Unable to settle, spending time between dayroom & bed area. Heard to be laughing loudly when lying on top of his bed. Unable to control same & unwilling to divulge why he was laughing. Offered & accepted PRN Lorazepam 2mgs @ 00.25 hrs. which had a gradual settling effect. Slept well from 01.00 hrs E Bleed
AM	Night duty report given to Dr Nunsey. Now prescribed small dose of Haloperidol B.D as Leon states he has experienced an acute dystonic crisis previously whilst in the ward. This has not been witnessed by any member of staff. Haloperidol to be increased if no side effects noted. Leon settled this am no complaints offered. Attended Multidisciplinary Group at 11am. Returned at 12.15 stating this had gone well. No evidence of side effects this duty. Capt
4 p.m	Relaxation Session: Attended full session with prompting. Active group member Behaved consistently appropriate Expressed own needs successfully Can follow verbal instruction. Leon stated he enjoyed the same. P Sands
Pm	Has attempted to contact his mother via the telephone on two occasions but has unsuccessful. Settled evening. No signs of side effects of medication. Rthapia.
28/3/02	Spent evening in the dayroom. Requested & given PRN Lorazepam 2mgs at 22.05 hrs appeared more settled & has slept well overnight. Capt
AM	Reluctant to rise this morning. Approached myself requesting PRN for agitation and troubling thoughts. Received Haloperidol 5mgs at 11.35 hrs to good effect. A Cha
1630	Offered relaxation group and declined. Rthapia
5(pm)	DR Edwards Team meeting. • Denies any inmatory hallucinations at present • Denies any current paranoid thoughts, however

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DATE	Leon Grattan NURSING NOTES – Continuation
28/3/02	Stan believes he had a good track prior
6.45pm	to admission
	• Complaining of feeling anxious and nervous
	• Haloperidol medication increased to 2mg BD TID
	• Dr Edwards meeting with Leon tomorrow 29/3/02
	• Depot medication 2 due Monday 1/4/02, Same to be clarified with Dr Edwards tomorrow
	• Escorted parole only at present. Same to be reviewed by Dr Edwards tomorrow Slathia
8.15pm	Leon has presented as fairly settled this afternoon and evening. Has reported no complaints. Slathia
29.3.02	Requested and was given Lorazepam 1mg at 22.40 hours
N/D	for agitation and settled to bed. He was seen at 01.30 hours complaining of agitation and feeling tense, Leon was offered and accepted a further Lorazepam 1mg at this time with good effect. Rthapliya
M	Fairly settled morning incompliance Rthapliya
	Met with DR Edwards today and pass granted from today until Monday 1.4.02. when he will return for depot medication and further review from DR Edwards. Working towards discharge next week Proceed on agreed pass in company of A Watson S/N, with return on Monday afternoon J. Mulligan
	To be reviewed by nursing staff upon return from pass on Monday 1/4/02, if pass has gone well, may continue on pass until Thursday 4/4/02.
	Ann Watson SW to visit Leon at home on Wednesday 3/4/02
	Dr. Edwards to review for discharge on Thursday 4/4/02.
19.20hrs	Telephone call received from Mrs Grattan (mother), enquiring if Leon was in the ward, advised he was on pass. Stated she could get no answer from him via telephone today, but states they are having no contact at present, since last Saturday. Spoke of Leon having been out on pass in her company last Saturday 23/3/02 for two hours, and Leon had spoken about having no access to his son, and wanted his mother to try and get access

DATE	NURSING NOTES – Continuation Leon Gratton.
	for him, which she is unable to do. Stated Leon spoke about having wished he had killed her last time. When asked to elaborate, stated that when Leon was 15/16 years old, he had tied a television arial around her neck, attached to a television, and thrown the television out of the window. + on another occasion had put his hands around her throat. Mrs Grattan felt at this time Leon was beginning to become unwell. Expressed concern that Leon has spoken of this past event now, and had also stated on 23/3/02, that the next time he will kill her.
	Stated that Leon had sent serious allegations via letter to ex-girlfriend at her work, and 5-6 weeks ago was charged by C.I.D. with breach of the peace. Stated that Leon does not leave his accommodation, as he is terrified, believing people will kill him, and are waiting for him. Mrs Grattan wishes an appointment with Dr. Edwards and will telephone his secretary on Tuesday 2/4/02 to arrange same.
	Above discussed with Dr. Nensey and Mrs Grattan advised to contact police, if feels threatened by Leon, or telephone the ward. A Graham
	Mrs Grattan stated she wishes to wait until her son apologises to her, regarding speaking about past incidents. A Graham.
1/4/02	Leon returned from pass, in the company of S/N Ann Watson. A Graham.
Am	
pm.	Depot given today and staff to consult with medical staff tomorrow re prescription of same. Appears relaxed and pleasant in presentation. J. Milligan.
2/4/02 NR	Generally settled around ward watching T.V. requested and received as required Zopiclone 7.5mg and Lorazepam 1mg at 00.25, before retiring to bed. Settled quietly and appears to have slept well overnight. [signature]
Am	LEON ROSE WITHOUT PROMPTING FOR BREAKFAST THEN RETURNED TO LIE ON TOP OF BED. 8AM MEDS WITHHELD AS KARDEX NOT CLEARLY WRITTEN. STAT DOSE SERTRALINE GIVEN AT 11:30. LEON SETTLED IN PRESENTATION NO MANAGEMENT PROBLEMS. [signature]
CONT.	DEPOT DISCUSSED WITH DR MINAZ WHO STATES NO DECISION WILL BE MADE TILL CLINICAL MEETING ON THURSDAY. [signature]
p.m	Remained settled in presentation during afternoon, approached staff requesting medication c/o increased agitation, no symptoms evident but given lorazepam 1mg @ 15.10 hours as per request. Settled @ time

DATE	LEON GRATTAN — NURSING NOTES — Continuation
	of report watching T.V. P. Hunter
2/3.4.02 N/R	Leon appeared quite restless during the earlier part of the shift. Requested and given PRN lorazepam 1mg and Zopiclone 7.5mg at 22¹⁵hrs. Eventually retired at 03⁰⁰hrs after several attempts to settle in bed. Appears to have slept since. L.A. Rimer
3/4/02	Dr Edwards [illegible] pass [illegible] APL
17:00	LEON INITIALLY SETTLED TILL STAFF APPROACHED HIM RE WHEN HE WOULD BE GOING ON PASS. HE INITIALLY STATED HE DIDN'T THINK HE WOULD COPE BEING OUT ON PASS BUT WAS UNABLE TO ELABORATE ON THIS. GIVEN SUPPORT AND ENCOURAGEMENT AND LEFT WARD AT 17.00hrs WITH HIS MOTHER. DUE TO RETURN TOMORROW. PRN LORAZEPAM 1mg GIVEN AT 14:20. APL
4/4-02 1900	Leon failed to return from pass, telephoning the ward instead stating that he was too tired to attend. No review could be made for discharge therefore Dr Edwards has arranged to meet Leon at Inverkeithing Medical Centre to discuss options for care. Planned to meet [illegible] at 9.30am on 5-4-02.
5.4.02	Leon failed to attend outpatient appt with Dr Edwards. to be placed on pass over the weekend to be reviewed by Dr Edwards on 8/4. He will discuss follow up with CPN, L. Mreedie on his return from annual leave. [illegible]
8/4/02 10:30	Leon telephoned ward this morning and spoke with Keyworker. Stated he had not attended meeting with Dr. Edwards on 5/4/02, as he had been unable to sleep the previous night, and had fallen asleep. Stated he had remained in his house over the weekend, but had called the police today, as states a mobile phone, and two remote controls had been stolen from his house. Stated police had visited this morning and taken relevant details. Appeared brittle in manner regarding same. Stated 'a guy is creeping in and out of the house', unsure of who this guy is, as he doesn't

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

11.45hrs Dr. Edward's informed of above telephone call. S/N McGoogan + Anne Watson s/w to visit Leon at home this afternoon at 2pm, to assess Leon within his home environment and if concerned regarding Leons presentation. Leon to return to the ward, to meet with Dr. Edward's this afternoon. If staying at home, Dr. Edwards will visit Leon at home on Wednesday 10/4/02 at 11.30am ? with CPN Lesley Tweedie.
S/N McGoogan to telephone Dr. Edward's following home visit to update.

11.50hrs Leon contacted and informed of home visit by S/N McGoogan + Anne Watson, Social worker + agreeable to same. Requesting S/N McGoogan takes pass medication with him and Leon states he has not had ~~pass~~ AG medication over the weekend. AGraham

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

10-4-02 Cfjt

pm Leon returned to ward around 11:30 this morning. Affect pleasant and appropriate in manner. Keyworker to meet with Leon this afternoon and discuss with him his mood / mental state while on pass and pass this onto Dr Edwards. Leon is also due increased depot of 150mg Clopixol. ——— Sett Elm

Leon met with keyworker SN Elvin today, after receiving depot medication. Remains paranoid requesting 7 day pass. Dr Nensey has requested

DATE	LEON GRATTAN NURSING NOTES – Continuation
	Leon remain in the ward until review by Dr Edwards tomorrow, to which Leon is agreeable. Metuse
	Requesting lorazepam 1mg at 18:00 for agitation, same given. Metuse
	Leon requested to meet. Leon expressing concerns that lorazepam was giving him "rushes" similar to those he experienced when using illicit substances. Leon requesting if there was any other form of medication that he could use for agitation. Advised that he could discuss this with Dr Edwards tomorrow at his meeting. Requesting passes tomorrow - reminded to discuss same tomorrow. Advised Leon unwilling to socialise in setting Leon are it was too noisy and other patients and had visitors. RShepherd
11.4.02	Settled evening. Spent short time in dayroom because of incident happening in corridor area of late unwell. He was later heard to be laughing loudly in the bathroom. Asked if he could sit with staff for a time in the corridor. Ordered and carry out pizza for his supper prior to retiring to bed. Has slept well overnight. E.Black.
(Pm)	Leon mother requested to speak with staff. She said that Leon knows he still unwell, she will clean same this week - MRS Grattan requested an update on Leon progress. Same given - Leon mother will not be into Leon next week, as she is going on Holiday. Slatthews
11/4/02	Leon bathed this morning and spent the remainder of the morning in the day room. Slightly agitated whilst talking with his mother. However settled and appropriate otherwise. ST/N Jandu and RShepherd
PM	Feedback from Dr Edwards Meeting • Still Expressing delusional beliefs • Accepted increase in increased medication/ depot • Lesley Tweedie completing referral to CCTT • Leon experiencing Anxiety Symptoms • Keyworker to if possible to Complete referral to OT re- graded exposure programme - as Panda or is meeting with Leon on Friday 12/4 to start Programme. • Pass Planned for Friday 12/4 over weekend telephoning monday 15/4 for review & condition

DATE	Leon Flatton NURSING NOTES – Continuation
	Continued • Keep bed for moment. V
11/4/02	Leon. Same in presentation no change. V
12:4:02	Leon retired to bed at 2200 hours and appears to have slept well
N/D	overnight rising at 0615 hours P Hutchison
1205	Leon due to go on pass as planned at 1400HRS pass meds done, on trolley ready. Settled on ward no change in presentation V
12/4/02	O.T. initial interview to discuss arrangements for a home visit on Wed. 17th April. Leon is happy to co-operate in graded exposure work with the OT for using public transport. P Cura OT
(p.m.)	proceeded on pass home over weekend, due to contact ward on Monday ~~15/5~~ 15/4/02, to inform staff, if pass has went well: pass medication supplied until 15/4/02 only S Crabbe
13/4/02	Referral to O/T Paula Cura, regarding graded exposure work
pm	as documented on 12.4.02 by o/t Paula Cura, completed A Graham.
16/4/02	Highlighted Leon's non-return from pass to Dr Nensey also no prescription of further depot medication. Dr Nensey in meeting CPN's Tweedie on Thurs AM, therefore no plan of care re depot will be given until then. T Metiven
13:30	Leon contacted ward requesting confirmation of O.T visit planned for tomorrow advised Paula not available today but will phone him in the morning to confirm. Leon was reminded he should have returned to ward on 15th - stated he plans to return tomorrow with O.T and confirmed pass is going well. P. Hemphrey
17/4/02	If Leon does not return, Lesley Tweedie to be informed
10.00	before 2pm & she will visit him. Awaiting clarification from OT Paula if she is visiting him today T Metiven
1215HRS	Leon returned to Ward this am laughing inappropriately with no obvious stimuli in day room requesting depot medication but explained this has not been written up therefore can not give. V
12.30	SEEN BY DR NORSEY DEPOT NOW CHANGED TO 200mg FORTNIGHTLY. AS LEON IS COMPLAINING OF OVERSEDATION ONLY 1mg LORAZEPAM PRN. TO BE ISSUED WITH PASS MEDS DEPOT TO BE GIVEN TODAY AND OVERNIGHT PASS MEDS SUPPLIED FROM TROLLEY
1400	Prior to staff being available to administer depot and supply medication, Leon was noted to have left the ward. As yet he has not returned therefore arrangements have been made for CPN Lesley Tweedie to visit.

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DATE	NURSING NOTES – Continuation
	Leon at home tomorrow and administer depot. Staff to confirm this arrangement with Lesley later today. to ~~confirm~~ either on. At end of shift Leon has not yet returned to ward. Lesley Tweedie to be contacted and will meet up with Leon tomorrow.
18/4/02	LESLEY TWEEDIE C.P.N. CONTACTED NEWLY WRITTEN KARDEX FOR DEPOT WHERE SHE WILL ADMINISTER THIS AT HOME. CARE WILL BE REVIEWED AT CLINICAL MEETING IN P.M. WHERE LEON WILL PROBABLY BE DISCHARGED ? LEON HAS ANY MEDICATIONS AT HOME.
	DR Edwards Team meeting • Returned to ward for clinical meeting • Reports mental state improved with better concentration • CCTT referral made by L Tweedie, for follow up • To receive depot Start of next week 200mg Clopixol 2/52, Lesley Tweedie unable to do same, on holiday. Staff to contact CCTT, to see if they can give Leon his depot next week. • Discharge today, follow up CCTT, Hillview Out patients and O.T. • Discharge medication ordered, Leon given enough medication until beginning of week, who ever does ~~he~~ Leon depot, to collect his discharge medication and take same out to him. • Gas level on, gas board found leak. • Mother is currently on Holiday in Spain.
	Discharged as planned above. Referral sent to John Allen to administer depot and deliver discharge medication. — A Dr.

fife healthcare NHS TRUST
MENTAL HEALTH SERVICE

GENERAL Observation Care Plan

Patient Name Leon Graham DOB 27.3.75 Unit No. .....

Ward TWO Responsible Consultant Dr Edwards

Physical Description

Height	Left	Hair	SHORT Brown.
Weight	13st 4	Build	Slim
Eye Colour		Dist. Features	

GENERAL Observation Approach

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

Reason for Approach / Risks Identified

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

Specific Interactions / Instructions / Constraints

15 minute timed interventions

15 minute timed interventions discontinued 18-3-02

NO specific timed interventions SB

Prescribing Nurse Signature Patricia Robertson Grade staff Nurse Date 17/3/02

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

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

Medical Signature ..... Date .....
(Note: A medical signature is not essential when upgrading status)

Review Notes Overle

Queen Margaret Hospital, Ward 2 **Care Plan** Key Workers: Alison Scott, Angie

Patient Name: Leon James Gratton

Date of Birth 17:03:75 Care Plan Number 1

Unit Number Date care plan initiated 18/3/01

Problem Statement:

Leon is presenting with paranoid beliefs that people are trying to kill him by gas poisoning resulting in restless agitated behaviour, disturbed sleep pattern and loss of appetite.

Patient's perception of identified problem:

Leon has little insight into his mental state at present.

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

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

Date	Interventions	Signature
18-3-01	Leon is admitted informally and is not detainable if wishing to leave.	Estelle
18-3-01	Administer medications as per Kardex and monitor the effects and side effects	Estelle
18-3-01	Encourage Leon to take reasonable dietary intake	Estelle
18-3-01	Give opportunity for Leon to ventilate his feelings regarding paranoid beliefs and assist in building a therapeutic relationship	Estelle
18-3-01	Allow Leon to discuss his nightmares give reassurance and provide suitable environment for sleep.	Estelle
18-3-01	Encourage Leon to use relaxation sessions as an aid to reduce anxiety and relief from voices.	Estelle
18-3-01	Leon is maintained on General observations with 15 minute timed observations - Discontinued 18.3.02 AGraham	Estelle
6/4/01	was maintained on general observations with no specific timed interventions.	AGraham
6/4/01	passes as agreed by medical staff.	AGraham

Care Plan Review Date

Queen Margaret Hospital, Ward 2

Care Plan

Key Workers Alison Scott
Sue

Patient Name: Leon Graffar

Date of Birth.....
Unit Number.....

Care Plan Number.....
Date care plan initiated.....

Date	Evaluation	Signature
30-3-02	Leon is on General observations with no specific timed interventions	Scott Ann
30-3-02	Leon's appetite has improved and he can now be responsible for his own dietary intake	Scott Ann
30-3-02	Leon's sleep pattern requires no specific intervention	Scott Ann

Care Plan Discontinued on .....(Date)

Goal Achieved **Yes / No** (Delete as appropriate)

Care Plan Rewritten on .....(Date)

NAME :- Leon Grattan. TEL NO -

DISCHARGE PLAN

DISCHARGE PREPARATIONS.

1. Planned date of discharge 18-4-02

2. Who initiated the discharge plan Dr Edwards / Leon.

3. Has there been a period of passes prior to discharge Yes.

4. Are discharge plans clear between the patient, keyworker, and medical staff. Relatives to be informed if directly involved. ✓

5. Patient reaction to discharge plans. Keen.

6. Prior to discharge referrals to appropriate supports are to be submitted.
   Hillview ✓
   C.P.N ✓
   Social work
   Key worker/O.T input ✓
   Others(specify)

7. Discharge medication ordered. ✓

8. Patient aware of date for out-patient /depot clinic appointment. ✓

9. Patients valuables are returned. ✓

10. Patient issued supply of discharge medication. ✓

11. Patients GP to be informed of discharge.

12. Patient issued a discharge line for D.S.S & discharge letter for GP. ✓

13. Documentation to be completed -: nursing notes/admission/discharge book ✓ ✓
    bed state folder ✓

14. Ensure case notes & profile are sent to the appropriate place

15. Remove patients name from keyworker board. ✓

Bayer

MULTISTIX* 10 SG REPORT

Name LEON GRATTAN Date 09.12.03

Ward 2 Patient No. _____

TESTS Please tick appropriate box for each test

LEUCOCYTES 1 to 2 minutes	NEG. ✓	TRACE	SMALL +	MODERATE ++	LARGE +++	
NITRITE 60 seconds	NEG. ✓			POSITIVE (any degree of pink colour)		
UROBILINOGEN 60 seconds	3 Normal ✓	16	µmol/l	33	66	131
PROTEIN 60 seconds	NEG.	g/L TRACE ✓	0.30 +	1 ++	3 +++	≥ 20 ++++
pH 60 seconds	5.0	6.0	6.5 ✓	7.0	7.5 ✓	8.0	8.5
BLOOD 60 seconds	NEG. ✓	NON HAEMOLYZED TRACE	HAEMOLYZED TRACE	SMALL +	MODERATE ++	LARGE +++
SPECIFIC GRAVITY 45 seconds	1.000	1.005 ✓	1.010	1.015	1.020	1.025	1.030
KETONE 40 seconds	NEG. ✓	mmol/L TRACE 0.5	SMALL 1.5	MODERATE 4	8	LARGE 16
BILIRUBIN 30 seconds	NEG. ✓			SMALL + ✓	MODERATE ++	LARGE +++
GLUCOSE 30 seconds	NEG. ✓	mmol/L 5.5 TRACE	14 +	28 ++	55 +++	≥111 ++++

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FIFE AREA LABORATORY
TELEPHONE MESSAGE PAD

Name Leon Grattan D.O.B. 07/3/75

Date 27/11/03 Time 14:35

ELECTROLYTES	Sodium	142	mmol/L
	Potassium	4.2	mmol/L
	Bicarbonate	27	mmol/L
	Urea	3.3	mmol/L
	Creatinine	98	µmol/L
GLUCOSE	Glucose		mmol/L
MISCELLANEOUS	Amylase		u/L
	Magnesium		mmol/L
CARDIAC	AST		u/L
	CK		u/L
	HBD		u/L
ARTERIAL BLOOD GASES	pH		-
	Base Excess		mmol/L
	Std Bicarbonate		mmol/L
	PCO2		kPa
	PO2		kPa
	Oxygen Saturation		%
DRUGS	Paracetamol	0.07	µmol/L
	Salicylate	0.07	mmol/L
LIVER	Total Bilirubin		µmol/L
	Albumin		g/L
	Total Protein		g/L
	Alk Phosphatase		u/L
	GGT		u/L
	ALT		u/L
BONE	Calcium		mmol/L
	Corrected Calcium		mmol/L
	Phosphorus		mmol/L
CEREBRO-SPINAL FLUID	Glucose		mmol/L
	Protein		mg/L

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

PHONE CALL TAKEN BY:-

Fife Primary Care NHS Trust – Mental Health Directorate

ADMISSION INFORMATION SHEET [A1-Dementia]

NHS Fife

Patients Name Lion Gratton. Unit No F5153833 Named Nurse .....

WARD Two Hospital QMH. Date/Time 27-11-03 15^45

1 Personal Information.

Known as	Date of Birth	Maiden Name
Lion.	17-3-75	Place of Birth Edinburgh.
Home Address 8F ~~Carling~~ Spittalfield Rd Invergowrie Kh11 1DZ	**Current Address**	**Telephone No** 01383 415625
Present/Past Occupation Labourer Glass factory	**Religion** Atheist.	**Ethnic Origin** White
Observation Status General.	**Allergies** Horse Hair	Is English first language Yes ☑ No ☐ Preferred Language Is an Interpreter wanted ☐ Is an Interpreter present ☐ Relationship to client *(if any)*

2 Main Carer (Other Relatives – Carer Information)

Full Name	Known as	Relationship to patient
Lorna Gratton		mother
Home address 41 Spittalfield Road Invergowrie	**Telephone No** 01383 420856	Does this person live alone Yes ☐ No ☐ Transport/problems in visiting
Detail of person to be contacted if patient is sick, dying or in any emergency Name	Relationship Address	Order of Contact: 1. _____ Cut off time _____ _____ Cut off time _____ _____ Cut off time _____ _____ Cut off time _____
Other Family support Name	Relationship Address	Other Relevant Information

3 Socio-economic details

Legal status on admission Informal ☑ Guardianship ☐ Care Programme Approach ☐ Mental Health Act ☐ Community Care Order ☐ Other – (Specify)	Mental Health (Scotland) Act – Section _____ Date commenced _____
Power of Attorney – Name _____ Guardianship/Curator – Name _____ Valuables/Property Book _____ Disclaimer form signed by Lion Gratton.	Welfare Power of Attorney _____ Welfare benefits received (Specify) Pension Book/s etc Keys

Other issues requiring to be managed;

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

Patients Name Lior Cranton Unit/CHI No F5153833

4 Diagnosis

Psychiatric Diagnoses	Physical diagnosis
? Schizophrenia.	
Psychiatric symptoms currently receiving medical/psychological treatment	**Medication received/Current Medication**
Depressive Symptoms.	Melatonin long norte Depot
Relevant Medical Conditions	

5 Community service involvement [includes name, addresses & telephone number.]

Name	Address	Tel No's
Consultant Psychiatrist Dr Cavanagh	C/o Ward 2.	
General Practitioner Dr Carmany	5 Friary Court, Inverkeithing	413234
Social Worker		
Community Psychiatric Nurse John Hamilton	C.O.T. Hansard House, Priory Lane	432725
District Nurse		
Care Programme Approach Co-ordinator	John Hamilton	
Home Care Manager		
Other involvement David Murrell.	Supporting People - Pitreavie.	

6 Special Needs/requirements

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

No problems.

7 Safety/risk problems/potential problems

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

Risk of aggression towards mother.

Fife Primary Care NHS Trust – Mental Health Directorate

ADMISSION ASSESSMENT / HISTORY TAKING [A1-Dementia]

NHS Fife

Patients Name Lion Gratton Unit/CHI No f.515.3833

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

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

Finding Lion to be paranoid, accusatory and irritating towards his.

9 Nursing observation of patient's mental state

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

Voicing Paranoid ideation, thoughts re: ex-partner, mother. Responding to voices he is hearing appropriately.

10 Nursing observation of patient physical state

Temperature 35.6° Pulse Blood Pressure 100/62

Urinalysis TRACE PROTEIN (09.12.03) SMALL BILIRUBIN Skin State Glasses Hearing Aid N.

Dentures Dentures Marked: Yes ☐ No ☐

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

General Appearance Tidy.

Distinguishing features Tattoo x6 Back/Neck.

Height 6ft 2" Weight 14ST Build Medium Eye Colour Blue

Hair colour Brown. Shoe Size Posture Erect.

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)

Pains in ribs ? cause.

13 Self Care problems experienced at home/previous care setting

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

Less motivation to attend to same.

14 Communication problems experienced at home/previous care setting

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

Swearing at mother - normal behaviour.

15 Confusion problems experienced at home/previous care setting

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

Paranoid Delusions.

Patients Name Lean Crotten Unit No 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)

Verbal/Physical aggressia towards mother.

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

18 Emotional problems experienced at home/previous care setting

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

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

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

Fife Primary Care NHS Trust

NHS Fife

GENERAL Observation Care Plan

Patients Name: LEON GRATTAN. **DOB:** 17-2-75 **Unit/CHI No.** .....

Ward: TWO. **Responsible Consultant:** DR CAVANAGH.

Physical Description

Height	6'	**Hair**	BROWN.
Weight		**Build**	MEDIUM.
Eye Colour		**Distinctive Features**	

General Observation Approach

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

Reason for Approach/Risks Identified

Special Interactions/Instructions/Constraints

NO TIMED INTERVENTIONS

Prescribing Nurse Signature: ..... **Grade:** E **Date:** 27-11-03.

Review

Date	Outcome	Date	Outcome

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

Nursing Signature: ..... **Date:** .....

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

Care Pathways

Fife Primary Care NHS Trust - Mental Health Directorate

Acute Inpatient - Admission to Hospital [F1]

NHS Fife

Ward /Dept 2.

Name: Leon Gratton.		Care Plan Number 1
C.H.I. Number	Unit Number F5153833.	Date Commenced 27/11/03
Consultant/G.P. Dr. Cavanagh.	Prescribed By Named Nurse: Linda Payne.	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	

re:

& Safety Advisory Service

ASSESSMENT FORM

ssessment

Date		
Weight kg:		
Height metres:		
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 affect safe handling:

Action plan discussed with client/carer yes/no

Date: 14/12/03 Signature: Linda Pamp Designation: ON

NHS Fife

Fife Primary Care NHS Trust – Mental Health Directorate

Care Notes [CN1]

Patients/Client Name: Leon Cranston

Unit Number / CHI: F5153833

Date of Birth: 17-3-75

Named Nurse/Key Worker: Alison, Linda, Steve

Date: Time:	*Multi Disciplinary Record of Important Information not held in Evaluation/Review/Variation Records etc*	Signature
27.11.03 18.25	Informal admission today of this 28 year old man well known to the psychiatric services. Referred to ward by C.O.T. Following overdose of Melatonin medication last night. Experiencing bouts of mood over past few weeks. Unable to sleep at present due to "voices" he hears at night. Last night felt unable to cope with voices and impulsively took overdose. Describes people having access to his thoughts and also receiving messages from the T.V. Plan: • Admit informally. • Place on general observations • Monitor mood + mental state • Assess for detainability if wishing to leave. Leon has spent much of the time since arrival on the ward pacing between day room and bed area. No interaction with fellow patients noted other than when directly approached. Pleasant on interaction with staff. Noted to be 'singing' to himself at times with no obvious stimulus. Visited by mother in the evening who describes several months worsening of symptoms. Mother also describes no sleep over past two nights.	
28/11/03	(NR) Up several times throughout the night, appears suspicious and guarded. Made conversation with staff member.	H McKechnie
12.30	Late to rise this morning, requires to attend to ms personal hygiene. Sullen in presentation Weekend Pass Plan From Dr ~~Beveridge~~ To may have may have escorted passes in hospital with staff, mother and WFCOT. Dr. No to confirm Depot medication this pm	T Gray T Gray
20.15	Leon has spent time constantly pacing corridor no interaction noted with other clients. Visited by his family during evening. Requested to be escorted to juice machine, appropriate in manner during this time.	P Hamilton
29/11/03 07.00	Generally settled in presentation & pleasant in manner on approach. Spent most of the night between dayroom & bedroom, has not slept at all.	C Reid

Patients/Client Name	Unit/CHI Number:
LEON GRATTON	

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

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

Date: Time:	*Multi Disciplinary Record of Important Information not held in Evaluation/Review/Variation Records etc*	Signature
30/11/03 cont'd	none of which he recognised except for one which was that of a student nurse he had developed feelings for on his 1st admission to the ward. He spoke of stress having feelings but stated he would not act on these as he knew the police would become involved. He spoke of the other voices, one he described as a girl screaming, others he stated were saying they were paedophile. He stated that he calls his mum as a diversion at times and that the voices do increase at night times. Reassurance and support given.	
1-12-03	Leon again concerned re voices. Accepted 2mg LORAZEPAM & 5mg HALOPERIDOL at 23.00hrs. He felt this was effective and requested his night sedation at 23.00hrs. Again has settled & slept well	J Traill
11.55	Dr Cavanaghs meeting:- • Monitor mood and mental State • Escorted passes in hospital grounds with staff members only	SBrs
12.25	Settled morning. Woken from bed to meet with Dr Cavanagh, appropriate throughout. Spent morning socialising in dayroom with fellow patients.	SBrs
20.50	Leon requested and received as required Haloperidol 5mgs @ 17.15hrs with some effect as he was becoming increasingly agitated as a result of distressing thoughts. He later requested and received as required Lorazepam 2mgs @ hrs with good effect. Leon's mum visited this ~~morning~~ evening (ERROR) the discussion become quite ~~loud~~ loud with Leon becoming increasingly brittle and aggressive in manner, however he eventually settled. Spent time in company of staff and was pleasant and polite. ~~Leon~~ Staff to contact CPN on AM to arrange for support worker to visit Leon for some escorted time off the ward within hospital if possible.	
1.12.03	Depot given today Clopixol 250 to D Side	

Patients/Client Name: LEON GRATTON

Unit/CHI Number:

Date: Time:	*Multi Disciplinary Record of Important Information not held in Evaluation/Review/Variation Records etc*	Signature
01 02.12.03	Quiet in presentation requested and given as required Lorazepam 2mg and Haloperidol 5mg at ~~22.05~~ 21.55, retired and has slept well overnight.	
12.15	Quiet and settled - spending slightly periods lying on bed. Has	
19.45	been not complaining of dry irritating skin between his fingers. Dr Johnstone has now prescribed Diprobase on a p.r.n. basis, some given @ 16.15 hrs. Leon's mother visited this evening and appeared to go well, both ~~seemed~~ appeared to enjoy some time and appeared more relaxed at times. Leon reports that the as required medication has been beneficial.	
3/12/03 06.30	Quiet in presentation requested & given as required HALOPERIDOL 5mg's at 21.55hrs retired to bed although unable to settle requesting LORAZEPAM, same had been discontinued duty doctor contacted & prescribed STAT dose Zopiclone 7.5mgs at 23.00hrs. with no effect. Again requested & given PRN 5mgs Haloperidol at 02.40 hrs. Leon has not slept at all overnight. Alert. TEAM MEETING:	
	• Tendencies to display ? paranoia re mother • Evidence of irritability towards mother • Using PRN Haloperidol as per border with effect • Prescribed Temazepam route to aid sleep • Continue pones within the hospital • Continue present care.	
	Unwell for AM, displaying no change in presentation.	
20.45	Visited by his mother this evening and although Leon appeared tense at times in her company, no overt paranoia evident on this occasion. did show some irritability on occasion towards mother. Settled otherwise around ward. Requested and given Diprobase cream at 2050 for skin irritation on his fingers.	
4pm	Requested and given as required Haloperidol 5mg for distressing auditory hallucinations, as per kardex, with effect.	

Patients/Client Name: LEON GRATTON. Unit/CHI Number:

Date: Time:	*Multi Disciplinary Record of Important Information not held in Evaluation/Review/Variation Records etc*	Signature
4/12/03 07.00	No change in presentation, quiet and generally settled during the evening received TEMAZEPAM 10mgs at 22.00hrs late to settle, eventually slept well from 01.00hrs.	E Reid
12.00hrs.	spent majority of morning in bed, attending day room for dietary and smoking purposes only Pleasant in manner, no further problems to report	K Hogan
9.10	Absconsion on presentation	
4/5.12	C.S N/R Spent evening in the sitting room watching TV, retired to bed around 00.30 and has slept soundly overnight.	E/N A. Ford
	Related Entry 4.12.03: Leon expressed his concern of having been prescribed Temazepam and although he agrees this is effective he is concerned re usuage of same as he became extremely addicted to same in the past. He spoke of Zopiclone being slightly effective, on further discussion it was noted that Leon had only ever been prescribed 7.5mgs agreed to speak with medical staff in the morning.	L. Gaffney
12.35	From Dr's meeting this morning, Dr Ho now prescribed Zopiclone ~~7.5~~ sleep 15mgs nocte. Melatonin remains prescribed until Dr Cavanagh attends Ward this afternoon as Dr Ho wishes to discuss this further as she is unsure how Dr Cavanagh wishes to proceed. Leon has spent a fairly settled morning	
	Weekend Pass Plan	
	Unescorted within / escorted out	
12.35	Contacted team to establish if it would be possible for escorted pass over today or weekend. Support Workers unable to assist today but will leave message for other staff members to establish if they can assist.	
5/12/03	Appearing pleasant and settled in presentation this P.M, visited by Mother and Son, observed to be appearing tense on occasion during visit. No complaints expressed	J Gallagher
05 5.12.03	Settled evening, spent time socialising with staff and fellow clients. Refused prescribed Melatonin at 10pm. Encouraged	
06.12.03	to retire and has slept well.	
7/1305	Leon was earlier to rise, was visited by his son and mother and spent time off the ward in their company. Colin Welsh from WF COT	

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

Date: Time:	*Multi Disciplinary Record of Important Information not held in Evaluation/Review/Variation Records etc*	Signature
	Will collect Leon tomorrow @ 10:30am and will escort him home to collect some belongings Leon aware of same.	
19.15	Leon appeared to be relatively quiet but conversed appropriately with staff & patients alike. Visited by his mother in the evening, and appeared to enjoy time.	Taylor
24.12.03 NR	Leon has slept very little overnight despite receiving Zopiclone 15mg at 10pm. Has spent the night drawing or writing his book. Remains settled in presentation.	
6.12.03	Community COT to take Leon home for clothing. No problems, Leon picked up clothes/CD's and came back to ward without complaint.	L.A Lennon
12.30pm	Rose early presenting overly bright and overly involved with fellow clients behaviour/ presentation. Escorted home by colin with as documented above.	S Cowan
1955	Spoke with Leon today Leon expressed he was bored on the ward and wished to know when he will be discharged. It was put to Leon that this issue will be discussed with Dr Cavanagh tomorrow at his meeting. Leon expressed that he was having difficulty sleeping at nights and that the night sedation he is receiving is not having any effect. Leon appeared tired although settled and good humoured throughout the session. He expressed that he is not currently experiencing distressing thoughts but is worried about financial problems which face him when he returns home.	
20.09.	Mrs Gratton on the ward to visit Leon requested to meet with myself S/N Drummond. Mrs Gratton was distressed at the manner in which Leon spoke to her, continually challenging her on issues. Mrs Gratton was very upset throughout the meeting, offered that she finds it difficult coping with	

Patients/Client Name: LEON CRAITON
Unit/CHI Number:

Date: Time:	*Multi Disciplinary Record of Important Information not held in Evaluation/Review/Variation Records etc*	Signature
	Leon and is worried about when he will be discharged. Support and reassurances given.	SDrS
2020	Spent pm between bed-side and dayroom. Quiet in presentation. Had visit from mother, recorded above.	SDrS
8.12.03 w/o	Leon settled in presentation this evening. He telephoned his mother and apologised for his behaviour earlier this evening. Leon retired to bed after his 10pm medication and appears to have slept well overnight.	P Hutchison
~~250~~	~~• Monitor mood and mental state.~~	
1050	DR CAVANAGH'S MEETING:- • Monitor mood and mental State • No passes @ present, to be reviewed mid-week by Dr Cavanagh. • Informal	SDrS
1205	Prompted to rise from bed by staff to meet Dr Cavanagh. Expressed he had a good sleep last night. Spent morning in dayroom watching TV with fellow patients.	SDrS
2000	During the course of the afternoon and evening Leon has presented quiet and slightly disgruntled, voicing feelings of boredom. Received depot as per Rota/ex, next due 15-12-03.	AM Keegan
9.12.03 w/o	Leon much more settled this evening. Leon sat in staff's company and initiated conversations appropriately. Leon retired to bed around midnight and appears to have slept well. Leon complaining of mouth ulcers. Advised that this would be dealt with by medical staff in the morning and in the meantime he should gargle with salty water.	P Hutchison
1005	Throughout the am spent time in the day room; quiet but co-operative in response to staff.	Rhead
15.00	Initial ward test of urine - trace protein, small bilirubin. Sent Sent to lab for screening.	Rae M
2035	LEON SETTLED IN PRESENTATION. APPROACHED MYSELF WITH PARENTS RE URINE TEST AND VITAL OBS TAKEN TODAY. PROVISED THIS APPEARED TO BE FOR BASE LINE AS SAME WAS NOT DONE ON ADMISSION. ALSO GIVEN REASSURANCE THAT "VOICES" HE COULD ~~HERE~~ HEAR IN DAY ROOM OF SOMEONE SITUATING FOR HOLP WERE IN FACT REAL NOT IMAGINED AS STAFF COULD ALSO HEAR THESE TOO.	EpL

Fife Primary Care NHS Trust – Mental Health Directorate

Care Notes - Continuation Sheet [CN1B]

Page No.....

Patients/Client Name: LEON GRATTAN

Unit/CHI Number:

Date: Time:	*Multi Disciplinary Record of Important Information not held in Evaluation/Review/Variation Records etc*	Signature
10.12.03	Settled evening and appears to have slept for long periods	P Hutch
N/D	TIMM MCGINLEY	
	• Showing improvement in mental state	
	• Less hostility voiced towards his mother	
	• Exercising feelings of boredom whilst on the ward	
	• Kw to refer to OT to alleviate above and provide structured activities to day.	
	• Sleep improved over past 3 days	
	• Showing some irritability in AM, settling as afternoon progresses.	
	• Tolerance present. Safe	
	• Passes as wishes.	
	In AM Leon left early but returned to bed again, only rising again prior to lunch	
		C/M Boogk
9pm.	Leon has appeared bright in mood this evening, sat time in company of male patient. No concerns expressed.	
		J. K
11.12.03	NIR Spent evening in sitting room before retiring to bed, prn Zopiclone given at 2200hrs, appears to have slept soundly	EN A Ford
13.10	Up at 10am, Spent time socialising with others in the dayroom. No problems noted.	L Boogk
2036	REMAINS SETTLED WENT TO CARE WITH DEREK ALLAN COT APPEARS TO HAVE ENJOYED SAME.	A/L
12.12.03	NIR Leon has slept very little overnight, despite receiving Zopiclone 15mgs at 10pm. Settled in presentation and pleasant in manner.	J Coles
	Leon invasive of staff's space at times last night and did kiss his counsellor had inwards, directed at one particular member of staff	P Hutch
1245	Pass medication ordered for overnight pass Date 13th → 14th. Appearing quiet.	
1445hrs	Settled in demeanour within the dayroom Leon Settled in presentation, conversation appropriate. Accompanied staff to shop. pleasant in manner throughout	L Boogk S Courtney
13/12/03	Settled evening, spent watching T.V. before	
06.30	retiring to bed, P.R.N Zopiclone given 15mgs and has slept well overnight.	C Reid
11AM	LEFT WARD ON PASS DUE TO RETURN 14/12/03 AT 9pm	
	PASS MONIES SUPPLIED.	A/L

Fife Primary Care NHS Trust – Mental Health Directorate

Care Notes - Continuation Sheet [CN1B]

Page No.....

Patients/Client Name: Lea Grattan.

Unit/CHI Number:

Date: Time:	*Multi Disciplinary Record of Important Information not held in Evaluation/Review/Variation Records etc*	Signature
11·10	Lea's mum spoke to D/C/N Gibson requesting an appointment with DR. Cavanagh to discuss both diagnosis & psychology.	CPayne
19·30	K/W met with Lea to ascertain how his pass went. Initially he says "fine". He then went on to describe how he had been "hearing voices" especially that of his ex-partner - whom he believed to be in a room above him "Shagging" his neighbour. He then expressed derogatory thoughts, beliefs re:- ex-partner and then his mother. Spoke of still feeling paranoid and elaborated upon this & of how "they" control his money and time spent with his son. Felt they were after him and how this was connected to his ex-partner & if he saw her, he would "rip her face off" & harm her. He did appear to be responding to the T.V. in the dayroom at tea-time. Lea spoke of coping with this by lying on his bed. Does not appear to have been sleeping well, claims his sleep pattern has been disturbed due to the voices.	CPayne
5.12.03	NF Spent time within the dayroom socializing with fellow patients late evening. Had a ramekin meal delivered which he shared with fellow patients after which he retired to bed. Appeared to have settled and slept well overnight.	JGdos
11.00	Seen by DR. Cavanagh this morning:- - Commenced regular dosage of Haloperidol 2mg B.I.D. - Due to current mental state. - No discharge date at present. - K/W to contact Lea's mum re:- meeting regarding Lea's care. Lea happy to have her involved & information to be discussed in front of her mum at meeting. - Dept. due today.	CPayne

Fife Primary Care NHS Trust – Mental Health Directorate

Care Notes - Continuation Sheet [CN1B]

Page No.....

Patients/Client Name: Leon Gration

Unit/CHI Number:

Date: Time:	*Multi Disciplinary Record of Important Information not held in Evaluation/Review/Variation Records etc*	Signature
	During the course of the AM Leon has presented generally quiet within the ward. When in discussion with Dr Cavanagh, Leon made no reference to any details as documented from discussion with RN last evening.	
RSO	Depot given as per kardex, next due on Monday 22nd December.	
20/12	Met with Leons mum at her request and with permission of Leon. She was expressing her concern regarding Leon's mental state and the lack of improvement with same. She also spoke of his pass home and how she had found him to be unmotivated with his son, wishing to stay within his flat on his own and wishing to remain in bed. Third party information Leons mother has been informed by her sister that Leon had called his aunty [illegible] and stated that he would not get better until she (mother) died. Leons mother has also found swords and ninja throwing stars whilst cleaning Leons flat. She advised that Leon is unaware of her knowledge of same and has not confronted him on these matters. Leon was polite towards his mother whilst hosting this evening Pleasant and appropriate whilst in staff's company but was overheard to be brittle in manner towards his father on the telephone.	
15/12.12.03	Settled evening, spent socialising and partaking of carry out meal. Reluctant to retire, eventually did so at 0300, and has slept well since.	
12.30hrs	No change in presentation, socialised freely with fellow clients.	
14.30hrs	Seen by DR HO, experiencing auditory hallucinations voices, hostilities towards mother. DR HO feels Leon mental state has deteriorated. Now only allowed short unescorted passes within hospital grounds.	
PTHO	IR the late afternoon Leon approached staff voicing his displeasure at being inpatient, requesting to be discharged. Due to this request, met with Dr HO. Outcome of this	

Patients/Client Name: LEON GRATTON. Unit/CHI Number:

Date: Time:	*Multi Disciplinary Record of Important Information not held in Evaluation/Review/Variation Records etc*	Signature
	meeting is as follows:	
	• Tied of being on the ward	
	• Feels people are making fun of him, but wont state any specific incidents	
	• Denies any intent to harm his mother	
	• Reports that his swords at home are for collection purposes only.	
	• Denies any auditory hallucinations except for ? hypnagogic auditory hallucinations last night	
	• Not detainable	
	• Accepts to stay inpatient at present	
	• Agreed for s/e pass on Thursday ⇒ Friday; and Sunday ⇒ Monday. If mental state does not deteriorate	A Graham
	Since this discussion Leon has made no more reference to wishing discharge, and has spent time in the company of others in day room.	D.M Boyce
1559hrs	Requested and given paracetamol 1gram for rib pain at 13:15hrs with good effect. —	S/Smith
17/12/08 07:00	Settled evening spent playing cards in dorm and has slept well overnight.	C. Reid
1235hrs	DR Canavash team meeting	
	• Admitted to DR HO yesterday, to be experiencing auditory hallucinations	
	• wishes DR Canavash to meet with his mother in his presence	
	• passes are already planned	
	• not detainable, however persuaded to stay if possible, if wishing to leave	
	Late to rise, presenting as generally settled and socialising well with others	S/Smith
2000	During the course of the afternoon and evening Leon has displayed no change to mood and mental state. Time spent within the ward in the company of fellow clients. Requested to meet Dr Ho, complaining of a painful arm. On investigation no injury noted.	D.M Boyce
18.12.08	Spent the evening playing cards with fellow clients. Retired and slept well.	T. Anderson
1200	In the AM Leon collected his pain medication and left the ward planning to return tomorrow	D.M Boyce
19/12/08	Returned from pass as planned, reports that pass had gone well	R Hyslop
1935	Leon requested to meet with myself prior to going	

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

Fife Primary Care NHS Trust – Mental Health Directorate

Care Notes - Continuation Sheet [CN1B]

Page No……..

Patients/Client Name: Leon Grattan

Unit/CHI Number:

Date: Time:	Multi Disciplinary Record of Important Information not held in Evaluation/Review/Variation Records etc	Signature
	I would phone again tomorrow as he has	
	no outgoing calls on his phone ——	[signature]
12 20	CONTACTED LEON AT HOME AS HE HAD NOT RETURNED	
	FROM PASS. STATES HE IS READY TO RETURN AND	
	SHOULD BE HOME SOON. LEON TO BE ADVISED	
	THAT JENNIFER HIS SUPPORT WORKER CALLED	
	WD SEVERAL TIMES AS SHE COULD NOT CONTACT	
	LEON AT HOME. SHE WILL NOT BE ABLE TO VISIT	
	TODAY	[signature]
1 30pm	Seen by Dr Cavanagh on return to ward. Discharge	
	home today, follow up FCOT and supporting	
	people. Discharge script done Leon, will return to	[signature]
	collect discharge medication tonight ——	[signature]
19.00	Discharge med issued to family. COT informed of	
	discharge, GP to be contacted tomorrow. Referral to	
	depot clinic undertaken ——	[signature]

Mental Health Nursing Service
Care Notes: Cont Sheet [CN1B] Feb 03: Review Feb 05

Fife Primary Care NHS Trust – Mental Health Directorate

Care Notes - Continuation Sheet [CN1B]

Page No........

Patients/Client Name	Unit/CHI Number:

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

Fife Primary Care

NHS Fife

MEDICAL - IN CONFIDENCE

ADMISSION DETAILS

UNIT/CASE REF. NO: | | | | | | | | | | | CHI NO | | | | | | | | | |

Surname GRATTON
Forename LEON
Title MR Initials
Previous Surname
Marital Status DIVORCED
Date of Birth 17.3.75 Sex (M/F)
Address 85 SPITTALFIELD RD
INVERKEITHING
Post Code KY11 1DZ
Have you been resident in the UK for the past 12 months? Y/N Y
Religion BUDHIST
Occupation UNEMPLOYED

Next of Kin or Responsible Party
Name HORNA ALLAN GRATTON
Address
Tel. No. 01383 510096
Relationship MOTHER
Emergency Contact
Name GARY GRATTON
Address 57 ORCHARD BRAE
MANCHESTER
Tel. No. 0161 776 1420
FATHER

G.P.'s Name GARMMAY
G.P.'s Address INVERKEITHING
HEALTH CENTRE
Admitting Ward ROTHES
Date of Admission 12/3/07
Time of Admision 02 10 hrs
CONSULTANT DR FEE

Status on Admission: (A) Voluntary
(B) Respite
(C) Compulsory
If Compulsory state: Act _____ and Section: _____
Start: Date ___/___/___ Time _____ _____ hrs
End: Date ___/___/___ Time _____ _____ hrs
Emergency Admission? Y/N N
Next of Kin to be notified? Y/N N
Admission precipitated by self-injury/poisoning? Y/N
Previous Psychiatric In-patient Care? Y/N Y
Hospitals of Previous Admissions: Ward 2 QMH

ADMISSION REFERRAL FROM: 9

1. Psychiatric Out-Patients
2. Psychiatric Day Unit
3. Transfer from other Psychiatric IP Care
4. Non-Psychiatric Clinical Ward
5. From Extended Pass/Leave of Absence
6. Prison / Penal establishment
7. Judicial / Court
8. Local / Regional Authority / Voluntary Agency
9. Other
A. Community Health Services Team
B. Self / Relative / Friend
C. Domiciliary Visit
D. GP

ADMISSION TRANSFER FROM: 40

11. Private Residence - living alone
12. Private Residence - living with relatives or friends
13. Private Residence (sheltered) - living alone
20. Usual place of residence: Institution, no additional detail added
22. Local Authority/Voluntary-Nursing/Residential/Hostel/GroupHome
23. Private - Nursing/Residential/Hostel/Group Home
30. Temporary place of residence, no additional detail added
33. Legal Establishment, including Prison
34. No fixed abode
40. Transfer from same Provider Unit, no additional detail added
4B. Geriatrics (except for patient on pass)
4D. Psychiatric (except for patient on pass)
50. Transfer from other NHS Provider Unit, no additional detail added

ADMISSION TYPE: 10

10 Routine Admission, no additional detail added
12 Patient admitted on same day or following day as attendance at Outpatients, not for medical reasons but because suitable resources are available
18 Planned transfer
20 Urgent admission, no additional detail added
21 Patient delay (for domestic, legal or other practical reasons)
22 Hospital day (for admin. or clinical reasons, e.g. arranging appropriate facilities, for test to be carried out, specialist equipment etc.)
30 Emergency Admission, no additional detail added
31 Patient Injury - Self Inflicted (Injury or Poisoning)
38 Other Emergency Admission (inc. Emergency Transfers)

ADMISSION REASON: 50

50 Psych. Admission, no additional detail added
52 Therapeutic/Clinical Crisis
53 Self Inflicted Injury
54 Poisoning
55 Accidental Injury
56 Other Injury
57 Rehabilitation
58 Other Type of Psychiatric Admission
5A Admission after Extended Pass
5B Respite/Holiday Care

ON COMPLETION PLEASE RETURN TO MEDICAL RECORDS

Fife Primary Care Division
Mental Health Directorate

NHS Fife

Observation Care Plan - GENERAL

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

Ward ROTHES Responsible Consultant 17.3.75

Physical Description

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

GENERAL Observation Level

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

Reason for level / Specific risks identified

Low mood suicidal ideation

11/3/07 suicide attempt (overdose)

Specific interactions and limits to be applied

No time out to allow a period of assessment.

To be reviewed by medical staff if wishing to leave.

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

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

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

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

Review Notes Overleaf

REVIEW NOTES

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

Mental Health Directorate

ADMISSION INFORMATION SHEET [A1-1]

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

Personal Information

FULL NAME: Mr / Mrs / Ms / Miss / Master LEON GRATTON	**Where appropriate, likes to be known as:** LEON **Date of Birth** 17.3.75 **Gender** MALE	**Previous or Maiden Name(s)** **Place of Birth** ~~17.3.7~~ MANCHESTER
Home Address 85 SPITTALFEILD RD INVERKEITHING **Post Code** KY11 1DZ	**Current Address** **Post Code**	**Marital Status** DIVORCED **Telephone No(s)**
Present/Past Occupation UNEMPLOYED	**Religion and/or Chaplaincy requirement** BUDDHIST	**Ethnic Origin** **Sensory Impairment problem (s)**
Allergies NONE KNOWN	**Is English first language?** Yes ☑ No ☐ **Preferred Language**	**Is an Interpreter required?** Yes ☐ No ☑ **Name (relationship to client, if any)**

MHA Status	Review Date	Patient Informed of Status By: / Date:	Clinical Risk	Does the Adults with Incapacity Act Apply;	Is there an Identified Relapse Signature?
INF			Yes ☐ No ☐ If yes; Specify Main Risk 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 LORNA GRATTAN	**Home Address** NOT KNOWN **Post Code**	**Telephone No.** 01383510096 **Relationship** MOTHER
(2) Full Name GARY GRATTON	**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 / FATHER	**Where appropriate - Order of Contact** MOTHER

Mental Health Directorate

ADMISSION INFORMATION SHEET [A1-1]

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

Diagnosis

Relevant Medical Condition:	**Medication Concordance:**
	POOR depot depixol 3amg weekly

Community Service Involvement

	Name/Address	**Tel No's**
LMHT/Community Team		
General Practitioner	DR CRICHTON'S INVERKEITHING H/C	
Social Worker		
Community Psychiatric Nurse	TOM SHORT C OT. HALWANE HOUSE	01383 432725.
District Nurse		
Care Programme Approach Co-ordinator		
Home Care Manager		
Chaplain		
Dependants		
Other involvement RI	RICHMOND SUPPORT	01383 622133

Patient Financial Information etc

	Where appropriate - Name/Address	**Tel No's**
Welfare Power of Attorney:		
Power of Attorney/Guardian/Curator:		
Pension Book etc held by:		
House Keys held by:		
Insurance Number:	NI -> JC 496564 A	
Advanced Statement held at/with		

Nursing Observations

Temperature 35.7°	Pulse 82	Blood Pressure 120/86

Signature of Person Completing this Form: Date:

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

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

Address: 85 Spittalfield Road Inverkeithing

Post Code: KY11 1DZ Gender male

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

Category of Risk	Assessment of Risk
From Others (e.g. abuse, exploitation)	Yes / No / Unknown
Details of identified Risk:	
To Self (e.g. suicide, self harm)	(Yes) / No / Unknown
Details of identified Risk: 11/3/07 - OD attempt (semi-impulsive act) continues to experience fleeting suicidal thoughts however no plans feels safe in hospital.	
To Others (e.g. aggression, violence)	Yes / No / Unknown
Details of identified Risk:	
Neglect (e.g. health, personal appearance)	(Yes) / No / Unknown
Details of identified Risk: Low mood - depressed appetite	
To Child(ren) (e.g. neglect, abuse)	Yes / No / Unknown
Details of identified Risk:	
Physical Impairment (e.g. medical, sensory)	Yes / No / Unknown
Details of identified Risk:	
Wandering & / or Falls	Yes / No / Unknown
Details of identified Risk:	
Memory and Cognitive Impairment (e.g. forgetfulness)	Yes / No / Unknown
Details of identified Risk:	
Challenges to Services (e.g. inappropriate demands, poor compliance)	Yes / No / Unknown
Details of identified Risk:	
Risk Taking Potential (e.g. positive resources, agreed plans)	Yes / No / Unknown
Brief details:	

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

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

.....

.....

.....

.....

.....

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

.....

.....

.....

.....

.....

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

.....

.....

.....

.....

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

.....

.....

.....

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

.....

.....

.....

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

.....

Comments:.....

.....

.....

.....

Need For More Detailed Risk Assessment & Management:

YES **NO**

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

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

Clinical/Kardex meeting

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
12/3/07	Interviewed by Dr Borlson	
	Requires further period of assessment	
	Request notes from QMH ✓	
	Confirm when depot was last given	
	and clarify other medication	
	Tom Short from Community Outreach Team	
	has been contacted.	[signature]
	Return call from Tom Short who confirmed	
	that Leon was on depot of Clopixol 30mg weekly	
	and last given 22/2/07.	
	Dr Howes contacted GP and confirmed dose of Nitrazepam	[signature]
13/3/07	Phone call from Tom Short to	
	state that depot is depixol 30mg	
	weekly. Also can't attend Thursdays	[signature]
	ward round.	
15/3/07	CLINICAL MEETING – following discussion	
	with Dr Cavanagh Dr Borlson has advised	
	Leon that he will be discharged today.	
	with follow up as per CPA care plan with	
	Dunfermline Team.	
	Dr Borlson will contact Leon's mother.	
	Tom Short CPN informed of discharge	
	and date of depot injection	
	Richmond Support informed of discharge	[signature]

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 – Mental Health Directorate

NHS Fife

Current Care Plan/Profile/Pathway Index Sheet - No. 1

Patient /Client Name Leon Gratton **Unit/CHI No:** ______________

Hospital: Whytemans Brae **Ward/Dept** Rothes

Care Plan Type	No	Date Commenced	Signature	Date End	Signature
Admission	1	12/3/07	C Spence		

Fife Primary Care NHS Trust – Mental Health Directorate

Continuation: Page 2

Name: ____ **Unit/CHI No:** ____________________

Care Plan Type	No	Date Commenced	Signature	Date End	Signature

Care Pathways

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

NHS Fife

Ward /Dept ROTHES WBH.

Name: LEON GRATTON		Care Plan Number: 1
C.H.I. Number	Unit Number	Date Commenced: 12/3/07.
Consultant/G.P.: FEE	Prescribed By Named Nurse: S/N MORAG DEAS	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	17/3/07.	6	
2		7	
3		8	
4		9	
5		10	

Patient/Client Name_____ Unit/CHI No _____

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

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

Patients/Client Name: KEON GRATTON

Unit Number / CHI:

Date of Birth: 17.3.75

Named Nurse/Key Worker: S/N MORAG DEAS

Date: Time:	*Multi Disciplinary Record of Important Information not held in Evaluation/Review/Variation Records etc*	Signature
12/3/07 (02.00)	Informal admission of this 31 year old gentleman following self-presentation to Accident and Emergency. Leon sought medical attention after taking an overdose of Loratidine 25mg x 10 tablets and paracetamol 8-10 tablets. Leon known to Psychiatric services with previous admissions to ward 2 Queen Margaret hospital. Transfered to Rothes ward due to lack of beds in ward 2. Presenting Complaint Leon stated his mood has been low for past 2-3 weeks experiencing fleeting suicidal thoughts, and automatic negative thinking "lifes not worth living" "fed up with life" "would be better off dead". Impulsive overdose attempt when at home (11/3/07) contacted The Samaritans who advised him to attend Accident and Emergency. Leon self presented at A+E and following psychiatric Assessment was admitted informally to Rothes ward. Past Psychiatric History. Known to psychiatric services previous admissions to ward 2. Queen margaret hospital. Attends Out patient clinic - Dr Cavanagh last seen him 2 months ago. Seen by Dr Lehany 2 weeks ago reduced Depot Dose at this time CPN - Tom Short. Diagnosis - Schizo-affective Disorder Borderline Personality disorder. Social History Lives alone in council flat receives Incapacity Benefit and DLA. Denies the misuse of illicit substances and stated he drinks alcohol on occasion not a regular drinker. Smokes 40 cigarettes per day.	

Patients/Client Name: Leon Gratton

Unit/CHI Number:

Date: Time:	*Record of Important Information not held in Evaluation/Review/Variation etc*	Signature
12/3/07 (cont.)	Leon has two sister living in manchester not a close relationship with sisters or father who also lives in manchester. Mother lives closer to Leon although Leon stated they too do not have a close relationship. Leon feels his mother "Puts him down all the time". Forensic History Leon stated he has attended court due to punching his mother in the nose. Leon presented - casually dressed unshaven although suggested growing a full beard average self-care, good eye contact throughout admission interview no further suicide plans at this time denied any perceptual disturbance stated experiencing auditory hallucinations "from time to time" last experienced same 4-5 weeks ago stated he "Can battle handle them" Denied taking overdose due to voices commanding him. Stated he has not been eating well and sleeping up to 12-14 hours has missed last two depot injections (clopixol weekly). Leon spoke of his Grandmothers death 4-5 weeks ago and feels same has had an affect on his current mood limited family support. Plan * Informal admission - Period of Assessment * Review by medical staff if wishing to leave. * Physical, Kardex, bloods done at QMH * ECG done - normal * Transfer to Ward 2 when bed available.	<Spunn
(04·00)	Retired to bed and appears to be resting	<Spunn

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

Date: Time:	*Record of Important Information not held in Evaluation/Review/Variation etc*	Signature
12/3/07	Leon has been quite restless, initially	
	eshing for discharge, but has since agreed	
	to remain for further assessment of mood	
	Was visited by his mother	MMcCaa
12/3/07	Received 20ml of Maalox at 13.30	
15.40	for heartburn P.R.N.	dhe Cal
16.40	Complained of feeling dizzy, advised to rest	
	at bed area BP 119/58 P 81 lying BP 102/72 P 116 standing.	
	Given advice on control of panicky symptoms	MMcCaa
20.00	No further reports of panic attacks and	
	appears more settled although has kept	
	his own company	MMcCaa
13.3.07	Leon retired to bed at 01.00h	
	Slept well until 04.45. States he	
	would like to stay in Rolls as	
	opposed to O.M.H. appears settled.	L Stevenson
13/3/07	Phone call from Dr Boilson who has	
14.30	liased with Dr Cavanagh at Ward	
	2 dunfermline. Leon's overdose appears	
	to have been a reaction to	
	receiving a phone bill for £500.	
	He has apparantelly been texting	
	a girl or girls. His mental health has	
	been deteriorating for a couple of	
	months and he has been phoning	
	people and threatening them (Persons	
	unspecified). He has been described as	
	a difficult patient who has a good	
	support package and tends not to	
	be admitted to ward 2 but gets	
	dealt with in the community.	
	Dr Cavanagh recommended that if Leon	
	is not Suicidal then it may be	
	relevant to discharge him. Dr Boilson	
	would like to receive Medical notes	
	prior to discharging.	dhe Cal
13/3/07	Leon requested PARACETAMOL Lapan at 12.35 for	
15.00	purpose of alleviating a headache.	LSTCL
13/3/07	Phone call from Tom Short, Leon's	
17.45	depot injection is deferred 3 days	
	weekly also stated that he can't	
	make Dr Boilson's clinical meeting	

Patients/Client Name: LEON GRATTON

Unit/CHI Number:

Date: Time:	*Record of Important Information not held in Evaluation/Review/Variation etc*	Signature
3/3/07	also stated that this is Leons	
17.45	first admission for a few years.	
	Leon also apparently paranoid regarding	
	people breaking into his house. —	
20.30	Visited by his parents this evening.	
	and noted to be very irritable with his	
	mother. claims that he is not getting	
	sufficient help for his anxiety symptoms	
	and despite reassurance regard	
	voicing perceived ideation expressing	
	concern that his flat is unsafe.	
	and has also been preoccupied with	
	thoughts that ex girlfriend will be raped.	
	Settled for a short period once patient	
	left but later approached staff	
	appearing angry and tense. Requested	
	and received lorazepam 1mg at 20.30hrs	M Bear
14307	Leon requested and received 1 gramme	
00.50	paracetamol for headache at 00.45h	
	as per Kardex.	L Stevenson
14.307	Leon has not gained much sleep	
	overnight spent most of it in	
	smoking sitting room. appeared to be	
	responding to auditory Hallucinations	
	after staff heard a outburst from	
	Leon in sitting room at 04.15h	
	retired to bed at 04.45 asleep	
	at time of written report.	L Stevenson
11.45	Visited by Richmond Support Worker	
	and taken out to bank	M Bear
14/3/07	Depot administered to left Side as	
16.30	Per kardex.	
14/3/07	Leon has spent most of the evening with fellow patients in the smoking	
19.30	room, apart from a supervised trip to the shop. Behaviour has been mostly	
	appropriate, however was observed gesticulating in the smoking room as	
	if in an argument with thin air or an hallucination. Was also overheard	
	in a heated conversation with someone on the telephone. No issues arising	
	from same. Settled at time of writing.	JIM SINCLAIR
15/3/07	Leon offering no complaints this evening	
	remains settled around ward has slept	
	well overnight.	M Keay

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
15/3/07	11.40hrs Leon was escorted to shop by staff. His mannerisms spending time in company of fellow patients playing cards. NB problems noted. —	DXXXXX
15/3/07	Discharged on recomendation from Dr	
19.05	Dobson, Tom short C.O.T informed, as was Richmond, DR CORDWATCH. —	[illegible]

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

Occupational Health and Safety Advisory Service / January 2002

Client Handling Assessment Form

A. Client Details/Assessment

A. Client details

Laou Gratton
85 Spittalfield Road
Inverkeithing
KY11 1DZ

Date		
Weight kg:		
Height mtrs:		
BMI		

Weight Bearing: (yes)/no

(Full)/Partial/variable

History of Falls: yes/(no) (please circle)

Equipment used by client:

wheelchair stick
hoist other .....
zimmer .....
rollator .....

Physical condition

Client's comprehension / communication

Handling constraints:

Behaviour which may effect safe handling:

Rehabilitation Programme:

Action plan discussed with client/carer yes/no

Date:	**Signature:**	**Designation:**

ROTHES WARD

DEPOT CARD

NAME: LEON GRATTON

FREQUENCY: ~~WEEKLY~~ (30mg)

MEDICATION: FLUPENTIXOL DECANOATE

LAST GIVEN	NEXT DUE	GIVEN BY
14/3/07 (AT)	21/3/07	

Mental Health Risk Assessment Checklist

Patient/Client Name LEON GRATTON

Date of Birth 7/5/15 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

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

Clinical History:
This patient suffers with blackouts.

Factual Report:

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

Myogenic potentials were seen when the patient was fidgety.

Activation procedures were unremarkable on this occasion.

Miss Louise O'Shea
Chef Technician
Victoria Hospital
Kirkcaldy.

Conclusion:
1. A normal EEG.

Dr. K.M. Spillane
Consultant Neurophysiologist
Kane wells Hospital
Dundee