Department of Psychiatry
St John's Hospital
Howden Road West
LIVINGSTON
EH54 6PP

201009798X

West Lothian

NHS
Lothian

West Lothian
Community Health and Care Partnership

Dr Pepper
Dedridge Medical Group
Dedridge Health Centre
Nigel Rise
Dedridge
LIVINGSTON

Date: 03.06.13
Dictation Date: 17.05.13
Our Ref: AL/KC/201009798X
CHI No: 1203893450
Enquiries to: [redacted]
Extension: 53787
Direct Line: 01506-523787
Direct Fax: 01506-523780

Dear Dr Pepper

RE: JAMES WEIR, 28 PEVERIL RISE, LIVINGSTON, EH54 6NU
DATE OF BIRTH: 12.03.89

I saw James in A&E on the 17th May 2013 presenting with anxiety and suicidal ideation due to surfacing of alleged childhood sexual abuse. He told me that he recently told family, friends and police about a 9-year history of sexual abuse by a friend who was a maths teacher. The last abuse was approximately 8 years ago. He feels very concerned about going through with the allegations and today was apparently found with a knife at his throat by his family. He had never told the doctor about any of these things. He described being very worried about his abuser's family find out.

Past Psychiatric History
Depression. Previous ODs and ADHD.

Alcohol/Drugs History
He has a history of alcohol excess although his last drink was more than 2 months' ago. He has used cannabis more recently and "*rock star*" tablets.

Personal History
James was born in Paisley and he described physical abuse by his mother and father. He did well at school and went to college for 3 years doing a HNC with possible access to nursing. He has mostly been engaged with factory work. His father is due to go to prison I believe for rape. He has 3 brothers and 5 sisters. He lives with his sister and holds down 2 jobs and is in a 10-year relationship with a baby due in 4½ months for which he wants to be a good father for.

Forensic History
He has been arrested by the police for carrying a knife.

Mental State Examination
He appeared well kempt but tearful. His speech was normal. He had suicidal thoughts although these have been chronic and was more acute recently due to the allegations surfacing. He described his mood as low and he appeared objectively low describing poor sleep and appetite. He tells me hears the abuser's voice in his head but recognises that this is in his head. He also has nightmares. He remained orientated and his insight was intact.

Opinion
Recent worsening of suicidal thoughts based on recent allegations of childhood sexual abuse. I reviewed this man with Elaine Ross, ACAST Charge Nurse and agreed that he could be discharged with some night sedation as he felt better after speaking to somebody after the

recent/

recent development. He is due to see his GP next week and we gave him the leaflet for Open Secret. I have not made an appointment for James to be reviewed in the outpatient clinic at this stage but if you feel that there are any ongoing psychiatric concerns please do not hesitate to refer him.

Kind regards.

Yours sincerely

DR ANDREW LEVER
GPST2 to Dr Rob Waller

DR SHANKAR.

INITIAL ASSESSMENT

NHS Lothian

1. Personal details

Date of assessment: 17 / 5 / 13.

Surname	WEIR
First name	JAMES
Preferred name	
CHI	1203893450
Date of birth	
MHI	
Address	28 Revenil Rise
	Livingston
	West Lothian.
Postcode:	EH54 6NU.
Telephone no:	

Sex:	(Male) / Female
Title:	
Surname at birth:	
Other previous surname:	
Ethnic group:	
1st language	
Interpreter required?	Yes / No
Occupation:	
Religion / beliefs:	
Address type:	Permanent / temporary
UK Resident last 12months:	Yes / No

2. GP details

GP	Dr Payne.
Practice	Dedridge.
Practice address	
Postcode:	EH54 6QQ.
Telephone no:	01506 414586
Fax no	

3. Next of Kin

Is NOK the named person? Yes / No

Surname:	
First name	
Relationship:	
Address:	
Postcode:	
Telephone no:	

Alerts

(e.g. allergies, safety issues)

ICD 10 category	

4. Legal status

MHA Section		Expiry date:
		Expiry date:
		Expiry date:
Advance statement	Yes / No	Where held:

5. Admission details

(Section 5 to be completed if admitted to hospital or other service)

Date of admission: ___ / ___ / ___	Ward/Service:
Time of Admission (24hr clock) :	Consultant:
Referred by:	key worker:

Medical records informed?: YES / No **(inpatient use only)**

Name:	CHI:	Date: ___ / ___ / ___

6 Details of those currently providing care (e.g. CPN, consultant, social worker, OT, psychologist)

Name	Relationship / Role	Address / telephone number/ e mail

7. Details of significant others (includes, **Named person (if different from NOK)**, carer, advocate and others that user wishes to be noted)

Name	Relationship / Role	Address / telephone number/ e mail

Ensure that you clarify and record below what type of information can be shared with whom and individual confirms with signature where possible

8. Assessor details

Time of assessment (24hr clock): 1900	Location of assessment: A+E
Primary assessor: A. Lauder	Designation: CPST2.
2nd assessor: Elaine Ross	Designation: ACAPT (Charge Nurse
Assessing team:	Referred by:
Factors affecting assessment (e.g. intoxication): BAC:	

9. Physical identifiers

General appearance:	Distinguishing features:	
Hair colour:	Height:	Build:
Eye colour:	Dentition:	

Name:	CHI:	Date: __/__/__

10. History of presenting complaint

Recently told family, friends, police about 8 year history of sexual abuse by friend who is a maths teacher – last abuse about 1 year ago
Feels very worried about going through with allegations.
Family found him with knife at his throat.
Never told any doctor about these things.
Feels very worried about abuser's family finding out.
Person alcohol excess, not drunk in 3/12.

Person's view of current situation:

Feels frightened and scared

Person's usual ways of coping and strengths:

Current crisis plan? Yes / No

Previously drinking
More recently – cannabis + other drugs.

Spiritual beliefs / needs:

Family history:

3 Brothers
M. 5 sisters.
Father in prison for rape – 15 years.

Personal history:

Born Paisley.
Physical abuse by mother and father.
Did well at school. University for 3 years – HNC – access to nursing.
Arrested by police for carrying a knife.
Factory work.

Name:	CHI:	Date: ___ / ___ / ___

Social circumstances: Lives with sister. Holds down 2 jobs - 60hrs/week. 10 year relationship, baby due in 4½ months.

Past Medical History & current physical health:

Hx alcohol excess. - ?

Past Psychiatric history:

Depression
Previous O/D's
MDHQ

Carer's view of current situation (including carer's usual role):

Does carer live at same address? Yes / No

Current medication (including over the counter medicines, note name, dosage, concordance)

Omeprazole.

Sources of information: service user / carer / GP / Pharmacist / Notes / Other

Alcohol use (note quantity):

Hx Alcohol excess - last drank 7/12 ago.

Risk of dependence / withdrawal: Yes / No

Other substance use: cannabis / Zoctober tablets.

Prescribed opiate substitute? Yes / No If Yes: Details of who dispenses:

Risk of dependence / withdrawal: Yes / No

Risk of blood borne viruses: Yes / No Smoker: Never / Ex / Current: _____ per day

Name:	CHI:	Date: ___ / ___ / ___

11. Assessment

Current mental state

Appearance & behaviour: well kempt. Tearful.

Speech, communication, any thought disorder: normal.
Suicidal thoughts - acute / chronic.

Mood / affect (including sleep and appetite)
S - Low
O - Low
Poor sleep and appetite

Thought content, abnormal beliefs, abnormal experiences
Hearing abuser's voice in head
Nightmares

Cognitive function: orientated /

Insight, judgement: Insight intact.

12. Risk Screening

Risk from others (e.g. abuse, exploitation, domestic violence) ☑ Yes ☐ No ☐ Unknown

Yes - 9 year chronic sexual abuse

Further investigation required? ☐ Yes ☐ No By Whom?

Risk to self (e.g. suicide, self harm, driving) ☑ Yes ☐ No ☐ Unknown

If drinking
assured

Further investigation required? ☐ Yes ☐ No By Whom?

Name:	CHI:	Date: ___ / ___ / ___

12. Risk Screening continued

Risk to others (e.g. aggression, violence, driving, access to weapons, supervision failure) ☐ Yes ☑ No ☐ Unknown

Further investigation required? ☐ Yes ☐ No By Whom?

Risk of neglect (e.g. health, personal) ☐ Yes ☑ No ☐ Unknown

Further investigation required? ☐ Yes ☐ No By Whom?

Risk to children (e.g. neglect, abuse) ☐ Yes ☑ No ☐ Unknown

Is there a risk to children due to mental state? (e.g. child included in suicide plans, delusional thinking). **A consultant psychiatrist should be directly involved in all clinical decision making for service users who may pose a risk to children.**

Further investigation required? ☐ Yes ☐ No By Whom?

Risk of physical impairment (e.g. memory, sensory) ☐ Yes ☑ No ☐ Unknown

Further investigation required? ☐ Yes ☐ No By Whom?

Risks relevant to service providers ☐ Yes ☑ No ☐ Unknown

(e.g. risks to staff, circumstantial or environmental risks identified for visiting staff)

Further investigation required? ☐ Yes ☐ No By Whom?

Sources of information available / used: service user / carer / family / police / 3rd party / PiMS / TRAK / other

Is Level 2 Risk Assessment indicated? ☐ Yes ☐ No **Responsible team:**

Name:	CHI:	Date: ___ / ___ / ___

13. Summary & plan

Summary of assessment (inc. summary of risk assessment, current needs)

CSA
Hx of CSA recently surfaced - family / friends.
Police now involved, although very anxious to go through with charges.
Feeling suicidal, family found him with knife at throat.
Last abuse more than year ago. Was a multiple attacks.
Work 60 hrs / week. 10 yr relationship. First baby on way.
Has ambivalence on future and desire to be good father.

Formulation /diagnosis

Anxiety / suicidal ideation due to alleged CSA.

Person's desired immediate outcome(s):

Home.

Is person medically suitable for admission to psychiatric inpatient care? Yes / No

Comment:

Management plan (inc. plan to manage identified risks)

Home to see sister.
Needs good night sleep. -
See GP next week.
Leaflet for 'open - secret'.
GP emailed

Discussed with: Elaine Moss.

Referred to: CMHT / IHTT / In-patient service* / GP / other (specify): _____

***If referred to in-patient services – complete immediate needs form with service user and /or carer**

If referred to in-patient services- briefly detail what alternatives were considered and why these were not possible:

Assessor- Name/Grade:	Signature:	**Date:**
[illegible] GRN 52		17 / 5 / ___

NHS Lothian

Ward 17

St Johns Hospital

Episode of Care

78260 SJ Pepper
201009798X M 12/03/1989

Name	**Weir, James T** 28 Peveril Rise, Livingston, West Lothian, EH54 6NU
Date of Birth / CHI Number	**CHI** 1203893450
Unit no	78260 SJ Pepper
Date of admission	8/7/13.
Date of discharge	
Consultant	Dr Shankar.
Keyworker	Tracey / Karina
SHO	Dr Tweedie

Information required for Ward Clerk:

Patient: name, D.O.B., Marital status, Phone no., Occupation, ethnic group, first language, religion.

Patient's GP: name, address

Next of Kin: name, address, phone no. if known

Consultant: name, ward, speciality, admission method, referral source

UK resident for 12 months?

Legal status?

Readmission status?

Are casenotes on ward?

Ethnic group categories These are the ethnic group categories that should be used to indicate the patient's ethnic group. **This should be the patient's own choice.** Where possible Patient should Choose ONE section from A to E, and tick appropriate box to indicate cultural background.	
A White ☐Scottish ☐Other British ☐Irish Any other White background, please specify:	**D Black, Black Scottish or Black British** ☐Caribbean ☐African Any other Black background, please specify:
B Mixed Any Mixed background, please specify:	**E Other ethnic background** Any other background, please specify:
C Asian, Asian Scottish or Asian British ☐Indian ☐Pakistani ☐Bangladeshi ☐Chinese Any other Asian background, please specify	

INITIAL ASSESSMENT

NHS Lothian

Date of assessment: 18/07/13

1. Personal details

Surname	201009798X/E2519401 M 12/03/1989
First name	**Weir, James T**
Preferred name	28 Peveril Rise,
CHI	Livingston,
	West Lothian,
	EH54 6NU
Date of birth	**CHI** 1203893450
	78260 SJ Pepper
MHI	
Address	
Postcode:	
Telephone no:	07580774081

Sex:	(Male) / ~~Female~~
Title:	Mr
Surname at birth:	
Other previous surname:	
Ethnic group:	
1st language	
Interpreter required?	Yes (No)
Occupation:	Soldier
Religion / beliefs:	
Address type:	Permanent / temporary
UK Resident last 12months:	Yes / No

2. GP details

GP	Pepper
Practice	Dedridge H/C.
Practice address	
Postcode:	
Telephone no:	
Fax no	

3. Next of Kin

Is NOK the named person? Yes / No

Surname:	[redacted]
First name	
Relationship:	Sister
Address:	
	Same as above
Postcode:	
Telephone no:	[redacted]

Alerts (e.g. allergies, safety issues)

Penicillin

ICD 10 category

4. Legal status

MHA Section		Expiry date:
		Expiry date:
		Expiry date:
Advance statement	Yes / No	Where held:

5. Admission details

(Section 5 to be completed if admitted to hospital or other service)

Date of admission: 01/7/13	Ward/Service:
Time of Admission (24hr clock) :	Consultant:
Referred by:	key worker:

Medical records informed?: YES / No (Inpatient use only)

Name:	CHI:	Date: ___ / ___ / ___

6 Details of those currently providing care (e.g. CPN, consultant, social worker, OT, psychologist)

Name	Relationship / Role	Address / telephone number/ e mail
[redacted]	Good friend	Kyrkliston, [redacted]

7. Details of significant others (includes, Named person (if different from NOK), carer, advocate and others that user wishes to be noted)

Name	Relationship / Role	Address / telephone number/ e mail

Ensure that you clarify and record below what type of information can be shared with whom and individual confirms with signature where possible

8. Assessor details

Time of assessment (24hr clock):	Location of assessment:
Primary assessor:	Designation:
2nd assessor:	Designation:
Assessing team:	Referred by:
Factors affecting assessment (e.g. intoxication): BAC:	

9. Physical identifiers

General appearance:	Distinguishing features:	
Hair colour:	Height:	Build:
Eye colour:	Dentition:	

Name: James Weir	CHI: 1203893450.	Date: 12/2/13

10. History of presenting complaint

Several years of feeling low in mood. Over past 6/12 ↑ agitation, jumpy, low mood, argumentative, loss of interest in appearance, ↓ appetite ↓ energy ↓ sleep – given diazepam to help sleep. ↑ suicidal ideation. Has not self harmed for 3/12. Thinking constantly of slashing wrists. Feels like he ~~has~~ is going to kill himself as so low but doesn't want to. Feels jumpy and paranoid, thinks people are talking to him or punching him. Brother committed suicide 2/12 ago on return from Army, and mother died last week from cancer. Several previous OD. Experiencing flashbacks to sexual abuse, tries to avoid social situations. Copes ok in Army

Person's view of current situation:

I want help.

Person's usual ways of coping and strengths:

Current crisis plan? Yes / No

spoke with partner. Now seperated

Spiritual beliefs / needs:

Family history:

alcohol as problem since teenage years, sexually abused age 17 by friend.

Personal history:

Born in Paisley, lived with both parents for first few years. Physical abuse from mum, on childs protection register, put in care. 2 sisters. parents split when 7, both mum and dad remarried. Abuse went on till age 18. In children's home age 12–16 due to abuse + behaviour. Sisters in home as well but seperated. Main stream school, ADHD, bullied. Got A Levels. When left got apprenticeship in Engineering, worked on ships for Army. Then applied to Army – 2yrs
Dad in prison for Rape. (TA)

Name:	CHI:	Date: __/__/__

Social circumstances lives c sister, however now homeless after argument c sister. On sick leave/compassionate leave from Army. 4th Bitallion based in Catterick. Seperated from partner baby due in 8/52

Past Medical History & current physical health:

alcohol XS
gastritis caused by chronic alcohol.
scarring of liver.

Past Psychiatric history:

ADHD – dx when age 4
Several ODs

Forensic: has been in prison as teenager for theft, carrying a knife

Carer's view of current situation (including carer's usual role):

Does carer live at same address? Yes / No

Current medication (including over the counter medicines, note name, dosage, concordance)

omeprazole. prescribed anti-depressant never took.

Sources of information: service user / carer / GP / Pharmacist / Notes / Other

Alcohol use (note quantity):

3 bottles buckfast daily last 6/12 – not every day 4-5 days per week. States vomits if not having alcohol.

Risk of dependence / withdrawal: Yes / No

Other substance use:

18/12 started to smoke cannabis occasionally
3/12 ago started smoking cannabis daily. Can not quantify.

Prescribed opiate substitute? Yes / No If Yes: Details of who dispenses:

Risk of dependence / withdrawal: Yes / No

Risk of blood borne viruses: Yes / No

Smoker: Never / Ex / Current: 25g per week. per day

Name: James Weir	CHI: 1203843450.	Date: 17/2/13

11. Assessment

Current mental state

Appearance & behaviour: appropriately dressed, unshaven. reasonable eye contact.

Speech, communication, any thought disorder

quiet, monotone no evidence FTD.

Mood / affect (including sleep and appetite)

dysthymic & blunted affect.

Thought content, abnormal beliefs, abnormal experiences

describes some features PTSD relating to sexual abuse 2yrs ago - flashbacks, avoidance.
paranoid of others, thinks they are talking to him when not.
No real auditory or visual hallucinations.

Cognitive function

Insight, judgement: intact. wants help.

12. Risk Screening

Risk from others (e.g. abuse, exploitation, domestic violence) ☐ Yes ☑ No ☐ Unknown

Further investigation required? ☐ Yes ☐ No By Whom?

Risk to self (e.g. suicide, self harm, driving) ☑ Yes ☐ No ☐ Unknown

states suicidal, states unsafe if goes home.
jumped from 15ft window today

Further investigation required? ☐ Yes ☐ No By Whom?

Name:	CHI:	Date: ___ / ___ / ___

12. Risk Screening continued

Risk to others (e.g. aggression, violence, driving, access to weapons, supervision failure) ☐ Yes ☑ No ☐ Unknown

Further investigation required? ☐ Yes ☐ No By Whom?

Risk of neglect (e.g. health, personal) ☑ Yes ☑ No ☐ Unknown

↓ appetite, poor personal care.
weight loss.

Further investigation required? ☐ Yes ☐ No By Whom?

Risk to children (e.g. neglect, abuse) ☐ Yes ☑ No ☐ Unknown

Is there a risk to children due to mental state? (e.g. child included in suicide plans, delusional thinking). **A consultant psychiatrist should be directly involved in all clinical decision making for service users who may pose a risk to children.**

Further investigation required? ☐ Yes ☐ No By Whom?

Risk of physical impairment (e.g. memory, sensory) ☐ Yes ☑ No ☐ Unknown

Further investigation required? ☐ Yes ☐ No By Whom?

Risks relevant to service providers ☐ Yes ☐ No ☐ Unknown

(e.g. risks to staff, circumstantial or environmental risks identified for visiting staff)

Further investigation required? ☐ Yes ☐ No By Whom?

Sources of information available / used: service user / carer / family / police / 3rd party / PiMS / TRAK / other

Is Level 2 Risk Assessment indicated? ☐ Yes ☐ No **Responsible team:**

Name: James weir.	CHI: 1203893650.	Date: 17/7/13

13. Summary & plan

Summary of assessment (inc. summary of risk assessment, current needs)

24yo ♂ referred by GP ? suicidal ideation. jumped from 15ft window today - STI ankle cleared by A&E.

Apparent Hx ADHD.

Eventful personal Hx + several recent stressors - death of mum, brother, relationship breakdown.

Evidence PTSD like features relating to alleged sexual assault

3/12 of agitation, anxiety, poor sleep, poor appetite + low mood.

Cannabis + alcohol a big problem.

Formulation /diagnosis

? EUPD, ? depression. ? PTSD.
However drugs/alcohol a big issue
On going suicidal ideation, no support network.
and ament symptoms → needs further ↓ assessment.

Person's desired immediate outcome(s):

Is person medically suitable for admission to psychiatric inpatient care? Yes / No

Comment:

Management plan (inc. plan to manage identified risks)

admit place of safety. - px happy - informal.
No TOW until senior R/V

Discussed with:

Referred to: CMHT / IHTT / In-patient service* / GP / other (specify): _____

*If referred to in-patient services – complete immediate needs form with service user and /or carer

If referred to in-patient services- briefly detail what alternatives were considered and why these were not possible:

Assessor- Name/Grade: THREDGE	Signature: LT	Date: 18/07/13

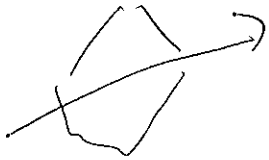
Physical

T37.7 HR 98 BP 120/72 Sats 96% alco 0·0

HWP PEARLA GCS 15

HS I + II + O.

 clear

 clear
SNT.

CN II - XII intact.

normal tone/power/sensation all 4 limbs

No evidence of alcohol withdrawal.

ankle, spine + C-spine discussed by A&E - no concerns.

will require pabrinex.

blood sent.

LT

MEDIC.

201009798X M 12/03/1989
Weir, James T
28 Peveril Rise,
Livingston,
West Lothian,
EH54 6NU
CHI 1203893450
78260 SJ Pepper

Physical examination (Nurse to complete sections 1-4 on admis

WARD 17

1. Observations

Height	5 ft: 9 in.	1.75 metres	reported / measured
Weight	9 st. 10 lbs.	62-3 Kgs	reported / measured
BMI	_____ Kg/m2	Underweight (<18.5) Healthy (18.6-24.9) Overweight (25-30) Obese (30-40) Morbidly Obese (>40)	
M.U.S.T.	Management: 0= Low risk – repeat screening	1= medium Risk- Observe	2= High Risk- Treat
Temperature	36.6 °C	normal / abnormal	If temp. is high repeat within 30 min.
Repeat temperature		normal / abnormal	If temp. is still high, start chart, inform doctor.
Pulse	73 bpm	regular / irregular	If pulse is < 60bpm or > 100bpm or irregular, repeat within 30min
Repeat pulse	bpm	regular / irregular	If still not within normal limits start chart, inform doctor
BP	116/67 mmHg	normal / abnormal	If BP is >130mmHG (syst) or 85mmHG (dias) repeat within 30 min
Repeat BP	mmHg	normal / abnormal	If BP still not within limits, start chart, inform doctor

1. Date completed: 18 / 2 /13 Time(24hrs) 23 : 00 Name : ...Anwar Signature: .....

If not completed at time of admission please state reason: .....

2. Opiate substitutes

Tick if Not applicable ☑

If the patient is prescribed an opiate substitute. Contact dispenser to cancel prescription during in –patient stay.

- Opiate substitute prescribed by:
- Requested to stop prescription by:
  (Name & Date)

2. Date completed: ___ / ___ / ___ Time(24hrs) ___ : ___ Name : ..... Signature: .....

If not completed at time of admission please state reason: .....

3. Allergies / sensitivities

*** Ensure relevant warnings are inserted in case notes, care plan & medication kardex**

Allergies*: Penicillin

Other sensitivities*:

3. Date completed: 18/2/13 Time(24hrs) 23 00 Name : ..Anwar Signature: ..Anwar...

If not completed at time of admission please state reason: .....

4. Smoking Status

Never smoked / Ex-smoker / Current smoker - number of cigarettes per day 50grams every 2 weeks

4. Date completed: 18 / 2 / 13 Time(24hrs) 23 : 00 Name : ..Anwar.. Signature: ....Anwar....

If not completed at time of admission please state reason: .....

Physical examination (Admitting doctor to complete on admission)

Name:
CHI:
D.O.B.
(or affix patient label)

WARD: .....

If physical not completed on admission please give reason below:

.....

Name: (admitting doctor)..... Signature: .....

5. Specific risk assessment for women of childbearing age Tick if not applicable ☐

1. Is patient currently pregnant? Yes / No / Uncertain (circle as appropriate)

⇨ If uncertain request pregnancy test.

⇨ If yes – review any current medications prescribed

- discuss any risks of medication in relation to pregnancy prior to prescribing medications

2. Is patient currently planning a family? Yes / No (circle as appropriate)

⇨ If Yes- discuss, as appropriate, issues relating to contraception or risk of becoming pregnant whilst on medication.

6. Physical examination

Physical Complaints:

General Condition: See Attached Sheets from Initial Assessment

Marks, Bruises etc.

Systematic Examination:

C.V.S

R.S.

A.S.

G.U.S.

Physical examination

WARD: 17

201009798X M 12/03/1989
Weir, James T
28 Peveril Rise,
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CHI 1203893450
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201009798X M 12/03/1989

Central Nervous System

Motor Functions- Power, Tone and Co-ordination:

Cranial Nerves:

I

II Acuity

Fields

Pupils

III IV VI

V Motor

Sensory

VIII Vestibular

Auditory

IX XI

X XII

Reflexes

B T K A ABD. PL

Right:

Left:

Sensation:

Fundi:

Summary or Comments:

Name/Grade of person completing physical:	Signature	**Date completed:** ___ / ___ / ___ **Time** (24hrs): ____:____

INITIAL CARE PLAN

Ward: 17

(To be completed by the admitting doctor following discussion with nursing staff)
Please ensure this form is signed, and date & time is completed

201009798X M 12/03/1989
Weir, James T
28 Peveril Rise,
Livingston,
West Lothian,
EH54 6NU
CHI 1203893450
78260 SJ Pepper
201009798X M 12/03/1989

1. Immediate needs

admit
bloods
Pabrinex
PRN diazepam in case evidence withdrawal

2. Service user desired outcomes

to get better

3. Initial planned care (up to next 72hrs)

Initial assessment.

Observation level	GENERAL / 15 min TOW smoke breaks

4. Medication prescribed

Symptomatic relief? Yes / No

Pabrinex 5+2.
diazepam.

5. Physical investigations

	Date completed	Date results reviewed	Comment / Action	Signature
U & E's*				
LFT's*				
TFT*				
FBC*				
Other				
Other				
Other				

6. Further information needed

Specify what & from whom

Was the service user involved in developing the care plan?	Yes / No
Has the service user consented to the care plan?	Yes / No

Name/Grade:	Signature	**Date:** 18 / 07 / 13
THOMPSON	CT	**Time** (24hrs): 23 : 15

Senior medical staff review

To be completed within 24 hours of admission

WARD 17

CHI 1203893450
78260 SJ Pepper
201009798X M 12/03/1989
Weir, James T
28 Peveril Rise,
Livingston,
West Lothian,
EH54 6NU
CHI 1203893450

1. Summary of review

24 YR OLD LONG HX TRAUMATIC UPBRINGING BEING IN CHILDREN'S HOMES, ABUSED, PRESCRIBED CIPRALEX FOR ADHD - SUSPECT EFFICACY, EARLY TRUANCY & DRINKING COMING TO ATTENTION OF POLICE FOR PETTY THEFT. MULTIPLE RECENT TRAUMATIC EVENTS OF BROTHER COMMITTING SUICIDE, MENTAL DYING & FATHER SENT TO PRISON FOR RAPING YNG GIRL. DESCRIBES POST TRAUMATIC SYMPTOMS CAUSED BY ACUTE DEPRESSION.

Please continue overleaf if required >>

2. CGI score

Please circle appropriate score

0= not assessed	1= Normal. Not at all ill	2= Borderline mentally ill	3= Mildly ill	(4=Moderately ill)
5=Markedly ill	6= Severely ill	7=Among the most extremely ill patients		

3. Working diagnosis

ACUTE DEPRESSIVE SYNDROME
? PTSD

Has patient been informed of diagnosis and rational for diagnosis? (Yes) / No

4. Aims of admission

1. DETOX from ACUM DEP
2. EDUCATION WITH WRAP
3. HOMELESSNESS PREVENTION

Does patient agree with stated aims of admission? Yes / No

5. Estimated length of stay

Circle estimated length of stay

(Up to 7 days)	8 to14 days	15 to 21 days	22 to 28 days	over 28 days

Reasons: LOW STAY ONTO PROBLEMS

6. Discharge criteria

1. AIMS OF ADMN MET
2. CGI 3

Name/Grade:	Signature:	**Date:** 14/7/15
Dr Stirling Cons		**Time** (24hrs): 10:00

1. Summary of review (continued

INITIAL CARE PLAN:

(1) INFORM ADMN - I DID NOT FIND HIM DESIRABLE.

(2) 1/2 HR PASSES WITHIN HOSPITAL GROUNDS

(3) CHLORDIAZEPOXIDE REDUCING REGIME PARKINEY | AT PCL KARDEX

(4) CHECK WITH NAT THE GASTROENTEROLOGY DONE DURG HIS LAST ADMN & WHAT F/U WAS ADVISED.

(5) FAX HOMELESS PROGRAM

(6) AA MEETINGS OVER WE

(7) REF TO WLAP DROP IN CLINIC AT [redacted] DIGBY ON MONDAY

(8) REF TO COMBAT STRESS - HOLYROOD TO SUPPORT HIS POST TRAUMATIC SYMP.

P MACKAY

78260 SJ Pepper
201009798X M 12/03/1989
Weir, James T
28 Peveril Rise,
Livingston,
West Lothian,
EH54 6NU
CHI 1203893450

Sheet No. 1

I.P. Multi Discip
Clinical Not
(Mental Health

Name:

Date	*Please sign and Print Name and Designation after your entry
17/7/13. 02[20] window	James is a 24yr old admitted Informally via A+E as requested by his GP. Jumped from 15ft today Mother had died of cancer last week although James states he was not close to her due to her physically abusing him and siblings when they were children. Has been staying with his sister at above address but wanted him out as has had enough of his alcoholism and has a young family and is pregnant. James is in the army but at present is on leave due to his present situation. Enjoys the army states that when busy in army he does not get flash backs of his mother's abuse, admits that he drinks heavily when in Army and on leave, has been drinking since the age of 12yr old. Then states that he was sexually abused by a friend at age of 17yr old which he also cant get out of his mind. James realises that he is needing to stop drinking but has been part of his life since a child. James smokes but understood and accepting that he is advised to stay in ward till Consultant review. Plus states he has no tobacco on him. Not wanting anybody to know ~~terror~~ he is in hospital at present time states he has got a good friend that

Date	*Please sign and Print Name and Designation after your entry
	he can speak too, number in admission notes. willing to stay in ward. NTO till reviewed, states very hungry, very apprehensive when shown round ward. Had something to eat and accepted the Pabrinex and PRN Diazepam and has since slept Aileen Wilson RN AWilson
18/19/07/13	Managed to receive his pabrinex, retired to bed and appeared to have slept well overnight. T. Nyoni/N T. Nyoni
19/7/13 1000hrs	CONSULTANT REVIEW BROTHER COMMITTED SUICIDE LAST YEAR - SLASHED HIS WRISTS USING ARMY RAZOR IN BARRACKS NEXT DOOR TO HIM. DAD SENT TO PRISON 4 WKS AGO (CONVICTED) (JAMES SMITH) FOR RAPING YOUNG CHILDREN. HE IS BEING ATTACKED IN THE STREET. CARE PLAN: SEE SR REVIEW SHEET R Pinnegar
18[00]	James came on walking group - spoke a lot about his life in army - seeming determined to get himself sorted. Pre-occupied with getting discharged on Monday - other patients supporting his need to be back home. Had a general conversation on how the service works - fellow patient assured him that we are fair. - I wondered about James's motivation to success in Army - can't drive - loses buses - has a pilots license - guide his statements re decision. In the group

I.P. Multi Disciplinary Clinical Notes

(Mental Health)

Sheet No. 2

Unit No. R038934-50

Name: James Weir

Date	*Please sign and Print Name and Designation after your entry
	so did not clarify what I heard as contradictory. [illegible] RMN
19.7.13.	Approached nursing staff this evening as he is concerned that he will be discharged on Monday. (Does not feel ready yet) Participated in walking group though reports it didn't go well as he vomited some blood during the walk - States he is still unable to keep food down & describes abdominal pain. Informed night shift re this. No other issues Catalina Carrowan RMN
19/20.7.13	Pabrinex administered @ 23[00] hrs, slow to settle utilised PRN Lorazepam prior to retiring with good effect. Has slept well overnight Denise Henderson R/N DENISE HENDERSON
20/7/13 1900hrs	James under pressure from sister to self DIC. Spoke with sister who wants him home as she has a disabled son + is pregnant + says James is over Person. (James says this is untrue.). He wanted limited info given to sis. only that he is here for detox she doesn't know of death of his mother + that he is nervy. Feeling stressed relaying use again feeling he cannot return to that situation on Monday. RMN T Clutton

WLT/871

Date	*Please sign and Print Name and Designation after your entry
20/7/13 22⁰⁰	Y ST4 Locum on-call Given 2 pairs I+II paracetamol IV Pt describes frequent vomiting / nausea (long standing) Prescribed liquid antiemetic PRN (Stemetil 10 mg) AD Nearly ST4
20/21-7-13 (07⁰⁰)	James evident around ward in evening — As previous report PARACETAMOL given as Kardex — Late PM requested to telephone Police (Military) as they had been at his Sisters yesterday AM — James is worried about this Matter — also he is concerned about Discharge — Slept on returning — R Fielding RFIELDING RN
21/7/13 1855hrs	Quiet day, no issues raised. Attended AA this evening. Clutch Recalled Rav
21/22-7-13 (05¹⁵)	James at AA meeting (20³⁰) — ON return mood quiet — spent time with F/P/Is — utilised 1mg LORAZEPAM @ 22⁰⁰ with Librium — Eventually retired approx 02⁰⁰. Slept throughout R Fielding RFIELDING RN
22/7/13	Dr walk. Finishing ~~detox~~ detox Home either today (if Homeless Hostel) or Wednesday (if less ideal). Follow up ① OPD 5 w/c Dr Tweedie ② Money into Health ③ ± Army Services for PTSD (not clear if he can access as still serving). Hewalker Cons 53787.
22.7.13 15.15	OT- James verbally consented to engage in the indoor curling group this afternoon. He remained appropriate and settled throughout, engaging well in discussion initiated by the OT staff. James appeared to work well and engage fairly in a team with f/p/Is and OT staff. He appeared to enjoy

I.P. Multi Disciplinary Clinical Notes

(Mental Health)

201009798X M 12/03/1989
Weir, James T
28 Peveril Rise,
Livingston,
West Lothian,
EH54 6NU

Date	*Please sign and Print Name and Designation after your entry
Cont-	his time spent playing indoor Kurling. (P) Continue to invite James to groups on the ward. FGallacher FCAM GALLACHER (OT) FG 22-7-13
22:7:13. Avg 1700	Overall settled day. Spent time off ward for cigarettes, participated in ward based activity which he appeared to enjoy. James also engaged with me in 1:1 discussion: Focus was how he plans to manage his alcohol addiction. He expresses motivation to address this and plans to continue engagement with AA. We discussed coping with craving including: his physical signs + feelings prior to alcohol use. We discussed stop + delay relapse prevention strategies: James able to identify several coping strategies which he could employ. I also made a worksheet regarding Pro's + Cons of alcohol use and Pros + Cons of no alcohol use: James plans to complete this in his own time. Referral sent to homeless / moving into health James has requested supported accommodation with CPN support. If available Dr Walker instructs James can go home today. If not continue admission until Tues or Wed then discharge. L Gemmell SWAN SI/N.
1845.	left ward and on return reported that he had met his brother: Consumed 1 bottle of Buckfast and taken 2 'rocksbar' (750ml)

Date	*Please sign and Print Name and Designation after your entry
22/07/13 cont.	ecstasy tablets (recently reported in news as being dangerous!) James reported vomiting shortly after doing this. On return to the ward. No obvious signs of intoxication. awake alert and responsive. reports feeling dizzy : lay on bed. Vital signs (1430) P90 reg. BP 106/58 T. 36.7c R.18
22-7-13 21-40	Fellow patients approached staff ~~custom~~ staff informing us that James, while out had taken overdose of paracetamol, spoke with James who confirmed this contacted duty doctor advised to contact HAN, overdose taken @ 20-20 states took 48 tablets. @Robert Dilnbert R/N
22/7/13	CTAS 3? ATSI NK ? PCT overdose 1) Ecstasy Excess 2) Suicidal ~~ideation~~ attempt in past 3) ~~Mental~~ Complex Hx History - PTSD, Abuse, Bereavement. This P.M took 1 bottle of Bucian + 2 ? Ecstasy tablets. → vomited. Then states that he took 48 Panadeine Bought from chemist. Regrets this now. Doesn't want to leave ED to go to Detox ~~Centre~~ Unit. Took nothing else O/E GCS 15/15 Pearl - Sews ⊙ - Abd soft. otherwise WNL Plan/ - Bloods AT 12[30] (1 hr) - ECG + PCT + Paracetamol - ECG - Watch obs (X 2 Hours Repeat) - Plan As PCT o.d IF required in ED. - Happy to ~~see~~ Review Again if required. 3991

I.P. Multi Disciplinary Clinical Notes

(Mental Health)

201009798X M 12/03/1989
Weir, James T
28 Peveril Rise,
Livingston,
West Lothian,
EH54 6NU
CHI 1203803450

Date	*Please sign and Print Name and Designation after your entry
23/7/13	Phonecall from HMP to be transfered to MAU
23/7/13	Telephone call from James sister - please see ~~note~~ Third Party. CPN1 ARMIT / Carol Anstey
23:07:13.	James presented on ward 17. Still under the care of MAU: I explained to him to return there due to the importance of completing physical treatment: Ward MAU made aware: will reinforce care plan requirements. Dr Waller has instructed. James can be discharged from MAU tommorrow if supported accomodation arranged. If not can return to ward 17. until wed. James aware of this! S&N. Discharge plan will remain as per 22/07/13
24/7/13	James once again presented on ward 17. Whilst under the care of wd 21. James wanted to discuss todays discharge plan. Advised to return to ward 21 and advised that information re discharge would be discussed once transferred to ward 14 /later today. Catherine FALCONER S/N.

Date	*Please sign and Print Name and Designation after your entry
24/7/13	Discharged from wd 17 today with support from [redacted] (homeless assessment officer - care centre, Livingston. Discharge meds provided. - Galea Encounter S/N

WARD 17 St John's Hospital	In-patient Notes Psychiatry	Name: James Weir. CHI: 120389 3458.

Date of Pre-Ward round discussion:..... Time: .....

To be completed with the client before the review meeting with the key-worker

Client's summary:

Key-worker's summary: [refer back to previous care plan]

Legal status:	*Informal*	*EDC*	*STCD*	*iCTO*	*CTO/CCTO*
Observation level:	*General*	*GOWC*	*Constant*	*Special*	

Mental health:

Physical health:

Groups & activities:

Family & community team feedback:

Key-worker recommendations:

Action points to discuss:

Signed on behalf of the meeting: *Signature:* ..... *Designation:* .....

Name: .....

Name

Weekly Care plan review

Working diagnosis	ICD-10

People present		int
patient	✓	
Nurse keyworker		
RMO	✓	
FY2/GPST	✓	
Medical student		
Social worker		
MHO		
advocacy		
OT		
Care/family		
Nursing student		
CPN		

Physical health issues

Currently being treated for paracetamol O/D with NAC on MAU. - taken in control of alcohol. Remorseful today.

MSE prior to meeting

referral	required	done
psychology		
CPN		
OT		
perinatal		
Rehab		
Addictions		
COT		
Post discharge group		

Mental health discussions

Discussed unclear nature of some facts differing from what sister says. Says has only known (half sister) for 4 months and that she is a 'control freak'.

Clinical global assessment
0= not assessed
1=very much improved
2=much improved
3=minimally improved
4=no change
5minimally worse
6=much worse
7=verv much worse

Identified risks

-

Identified strengths

- keen to engage with community services / AA.
- not currently suicidal.

Personal goal and 7 day treatment plan

1. D/c from MAU. - Homeless accomm.
2. Engage & Ring into Health. - Referral made.
3. Homeless CPN. - AHO exploring Bethany House.
4. AA.

Observation status		
Pass plan		
Kardex		
Legal status		
High dose		

Signature _____ Print Lizzie _____ date 23/7 Designation GPST2.

Fax Send Report

22-JUL-2013 13:37 MON

Fax Number : 01506524313
Name : WARD17

Name/Number : 901506282846
Page : 3
Start Time : 22-JUL-2013 13:35 MON
Elapsed Time : 01'20"
Mode : STD G3
Results : [O.K]

Fax

NHS Lothian

Date: 22.7.13

From:

Ward 17
St Johns Hospital
Howden Road West
Livingston
EH54 6PP
Tel: 01506 524117
Fax: 01506 524313

To: Homeless Presentation
Moving Into Health.

Number of pages inc this one: 3

Fax

NHS
Lothian

Date: 22.7.13

From:

Ward 17
St Johns Hospital
Howden Road West
Livingston
EH54 6PP
Tel: 01506 524117
Fax: 01506 524313

To: Homeless Presentation
Moving Into Health.

Number of pages inc this one: 3

West Lothian Council

NHS Lothian

West Lothian Community Health and Care Partnership

Moving Into Health West Lothian

Hospital Homeless Presentation Request
- St John's Hospital -

Notification of Homelessness Status
(Please inform Moving into Health as soon as possible. If you have any queries phone 01506 282010)
movingintohealth@westlothian.gov.uk

1. Person Making Request

Name Tracey Mutch

Ward / ~~Dept~~ 17

Tel. No. 01506 524117

2. Applicant

Full Name James Weir

Date of Birth 12/3/89

Last Address 28 Peveril Rise Livingston.

Date of Admission 18/07/13

Is there any anticipated delay in discharge / indicate potential
James' reluctance
Discharge date 22/7/13.

3. Medical Diagnosis / Current Problems / Medication

Alchalol problem since teens Brother completed suicide 2/12
Suicidal thoughts Mum died last wk from cancer.
Detox - librium + pabrinex.

4. Events which led to Homelessness / Housing Need

Difficult dynamic within family causing difficulties for James

5. Brief Details of Discharge Plan *(please state which services the applicant has been referred to and/or will continue to see e.g. Psychiatry follow-up, District Nursing Service, COT, SWAT, SDRT and confirmed appointments known and what the service will offer) (The name of professionals involved with phone number would be helpful to allow notification of change to address)*

Refer to WLAP Drop in Clinic
ref to Combat Stress Holybush.

6. Details of likely follow-up / discharge plan and Professionals involved *(e.g. Medical Staff, CPN, District Nurse, Social Worker, Health & Homelessness Team, Richmond Fellowship, Penumbra, SAMH, and SWAT). Please state which services*

As above. Client has indicated Supported housing would be of benefit. - Bethany House: Bathgate
- Blackburn.

7. Support Network *(e.g. family, friends & social / family circumstances)*

AA is supportive.; Also supported housing has been of benefit in the past. Family supportive when James not drinking!

8. GP Details

Name of GP Dr Pepper

Address Deadingale HIC Tel. No.

9. Risk Factors *(brief details – self harm, suicidal ideation, child protection…) Are there Adult Protection/MAPPA/Mental Health Act protocols in place / please inform.*

Suicidal ideation. NO DSH for 3/12

10. Relevant Other Information, including reason for admission, emerging features
(e.g. disability, mobility, support needs, risk factors including forensic & child protection)

: Recent drop in mood : suicidal thoughts.
: Increase in alcohol use (already history of dependency).
: Increased risk to self -

11. Can the Applicant travel to the Area Housing Office for an Interview?

Yes ☑ No ☐

This has been shared with the applicant, who agrees with the information.

Signature of Applicant

Signature of Professional Date 22:07:13

Please fax this information to Moving into Health Team on 01506 282846
(Out of hours evening and weekends contact 01506 280000).
Who will in turn pass information onto Housing Needs Team to initiate Housing Needs Assessment.

If you require any information please contact Moving into Health 01506 282010.

Fax Send Report 26-JUL-2013 09:26 FRI

Fax Number : 01506524313
Name : WARD17

Name/Number : 901506282846
Page : 3
Start Time : 26-JUL-2013 09:25 FRI
Elapsed Time : 01'12"
Mode : STD G3
Results : [O.K]

Fax

NHS Lothian

Date: 26.7.13

To: Moving Into Health

From:

Ward 17
St Johns Hospital
Howden Road West
Livingston
EH54 6PP
Tel: 01506 524117
Fax: 01506 524313

Number of pages inc this one: 3

Please find attached a referral form re Mr James Weir.

Fax

NHS
Lothian

Date: 26.7.13

From:

Ward 17
St Johns Hospital
Howden Road West
Livingston
EH54 6PP
Tel: 01506 524117
Fax: 01506 524313

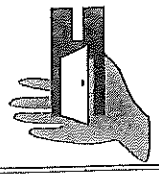
To: Moving Into Health

Number of pages inc this one: 3

Please find attached a referral form re Mr James Weir.

Moving Into Health, West Lothian
Homeless Health Team

For further information call: - 01506 282808/282809/282810 Fax: 01506 282846



- Referral Form–

Name JAMES WEIR. **DOB** 12-03-89.

Current Address No fixed abode. **Tel** 07527778689

Preferred mode of contact:

Current Legal status: informal.

Other Agency Support:

GP Details: Dr Pepper
Dedridge Health Centre, Livingston.

Last known address & current circumstances:
28 Peverel Rise,
Livingston, EH54 6NU.

REASON FOR REFERRAL:

No fixed abode.

Health Concerns: (It would be helpful to indicate if discussed with client)

Physical Health: NO ISSUES

Mental Health: Does not give accurate information re social stressors.

Medication:

Any known risk factors (lone working/risk to self or others): None known
(please attach your risk assessment) past and present

Are there any current/past child protection issues? None know.

Other helpful information

This information may be shared with other professionals, to help offer you the best service.

Please state exceptions.

Do you agree with this? Yes ☐ No ☐

Client Signature _____

Client Printed Name _____

Referrers Signature _____

Referrers Please print name CORINA FALCONER.

Date 24/7/13.

NHS Lothian

Working in partnership

Please return to:

Homeless Health Team
Moving Into Health
West Lothian Civic Centre
Howden South Road
LIVINGSTON
West Lothian
EH54 6FF

University Hospitals Division

St John's Hospital at Howden
Howden West
Livingston
West Lothian
EH54 6PP

NHS Lothian

Department of General Psychiatry

Dr Pepper
Dedridge Medical Group
Dedridge Health Centre
Nigel Rise dedridge
Livingston
EH54 6QQ

Date First Created 22/07/2013
Date Authorised
Date/Time Printed 22/07/2013 15:26
Our Ref 201009798X
CHI 1203893450

Patient: James T Weir
28 Peveril Rise
Livingston
EH54 6NU

UHPI: 201009798X
Date of Birth: 12/03/1989

Ward: Ward 17 SJH

Admission Date: 18/07/2013

Consultant: Dr Prakash Shankar

Discharge Date: 22/07/2013

Discharge Medication	Dose	Frequency	Duration	Additional Info
Diazepam Tablets	5 MG	TWICE DAILY	1 Week	not to be continued after one week Amount Dispensed: 14
Thiamine Hcl Tablets	300 MG	ONCE DAILY	3 Months	please continue for three months Amount Dispensed: 21
Vitamin B Co Strong	2 TAB(S)	THREE times DAILY	1 Week	for one week only Amount Dispensed: 42

Prescribed By ..... **Date** ..... **Print Name**.....
Dispensed By ..... **Date** ..... **Print Name**.....
Pharmacist Check ...[signature]..... **Date** 22/07/13 **Print Name** [illegible].....
Final Check ..... **Date** ..... **Print Name**.....

PRINCIPAL DIAGNOSIS/PROCEDURE
alcohol dependency, low mood, possible PTSD, homeless
TREATMENT
detox and stabilisation
recent bereavement [of mother]
FUTURE INVESTIGATIONS AND FOLLOW-UP BEING ARRANGED BY HOSPITAL
OPD5 in one week [dr shankar's team]
Moving into health homeless CPN team
contact with combat stress / VFP [if able to - some confusion as he is still serving in the army but on the sick]
CHANGES TO DRUGS SINCE ADMISSION
given small supply of diazepam on discharge
post-alcohol vitamins as above
not on antidepressant - might be a future optio0n
PREVIOUS ADVERSE DRUG REACTIONS

West Lothian CHCP

Chair: Frank Toner
Director: Jim Forrest

Rehabilitation:
Dr J Hendry
01506 523777
Dr C Kenwood (Lead)
01506 523787

Intensive Care:
Dr L Mowatt
01506523771

Liaison:
Dr H Aditya
01506 523772
Dr S Kennedy
01506 523772
CNS P McManus
01506 523772

General Adult:
Dr A Al Sayegh
01506 523792
Dr K Bett
01506 523792
Dr L Mowatt
01506 523771
Dr P Shankar
01506 523771
Dr R Waller
01506 523787

Older Adults:
Dr A Beaglehole
01506 523786
Dr S Roscrow
01506 523759

OPD5 Appointments:
Tel: 01506 523770
Tel: 01506 524411
Fax: 01506 523780

University Hospitals Division

St John's Hospital at Howden
Howden West
Livingston
West Lothian
EH54 6PP

NHS
Lothian

Cont'd... **Ref:** 201009798X **Patient Name:** James T Weir

NKDA
SIGNIFICANT CHANGES MADE TO CARE ARRANGEMENTS
homeless presentation
GP to please consider the following...

Should you need further information please contact...

Information contained in this letter has been discussed with the patient/carer.

Yours sincerely.....

Staff Signature..... PrintName.....

Designation..... Date..... Time.....

Patient/Carer Signature.....

This is an immediate discharge letter and a further letter may follow.

University Hospitals Division

St John's Hospital at Howden
Howden West
Livingston
West Lothian
EH54 6PP

NHS Lothian

Department of General Psychiatry

Dr Pepper
Dedridge Medical Group
Dedridge Health Centre
Nigel Rise dedridge
Livingston
EH54 6QQ

Date First Created 22/07/2013
Date Authorised 26/07/2013
Date/Time Printed 26/07/2013 13:55
Our Ref 201009798X
CHI 1203893450

Patient: James T Weir
28 Peveril Rise
Livingston
EH54 6NU

UHPI: 201009798X
Date of Birth: 12/03/1989

Ward: SJH Medical Assessment Unit

Admission Date: 18/07/2013

Consultant: Dr Prakash Shankar

Discharge Date: 24/07/2013

Discharge Medication	Dose	Frequency	Duration	Additional Info
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Vitamin B Co Strong	2 TAB(S)	THREE times DAILY	1 Week	for one week only Amount Dispensed: 42

Prescribed By ..... **Date** ..... **Print Name**.....
Dispensed By ..... **Date** ..... **Print Name**.....
Pharmacist Check ..... **Date** ..... **Print Name**.....
Final Check ..... **Date** ..... **Print Name**.....

PRINCIPAL DIAGNOSIS/PROCEDURE
alcohol dependency, low mood, possible PTSD, homeless
TREATMENT
detox and stabilisation
recent bereavement [of mother]
FUTURE INVESTIGATIONS AND FOLLOW-UP BEING ARRANGED BY HOSPITAL
OPD5 in one week [dr shankar's team]
Moving into health homeless CPN team
contact with combat stress / VFP [if able to - some confusion as he is still serving in the army but on the sick]
CHANGES TO DRUGS SINCE ADMISSION
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Dr A Al Sayegh
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Dr P Shankar
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Dr R Waller
01506 523787

Older Adults:
Dr A Beaglehole
01506 523786
Dr S Roscrow
01506 523759

OPD5 Appointments:
Tel: 01506 523770
Tel: 01506 524411
Fax: 01506 523780

University Hospitals Division

St John's Hospital at Howden
Howden West
Livingston
West Lothian
EH54 6PP

NHS
Lothian

Cont'd... **Ref:** 201009798X **Patient Name:** James T Weir

NKDA
SIGNIFICANT CHANGES MADE TO CARE ARRANGEMENTS
homeless presentation
GP to please consider the following...

Should you need further information please contact...

Information contained in this letter has been discussed with the patient/carer.

Yours sincerely.....

Staff Signature..... PrintName.....

Designation..... Date..... Time.....

Patient/Carer Signature.....

This is an immediate discharge letter and a further letter may follow.

Department of Psychiatry
St John's Hospital
Howden Road West
LIVINGSTON
EH54 6PP

Dr Pepper
Dedridge Health Centre
Nigel Rise
Dedridge
LIVINGSTON
EH54 6QQ

Date: 05/08/13
Dictated: 05/08/13
Our Ref: LT/FS/201009798X
CHI No: 1203893450
Enquiries to: [redacted]
Extension: 53771
Direct Line: 01506 523771
Direct Fax: 01506 523780

INPATIENT DISCHARGE SUMMARY

Dear Dr Pepper

Mr James Weir, Dob 12/03/89
35 Pyothall Court, Broxburn, West Lothian, EH52 6GX

Date of Admission: 18/07/2013
Date of Discharge: 24/07/2013
MHA Status: Informal
Consultant: Dr Shankar
Ward: 17, General Adult Psychiatry

Impression:
1. Alcohol dependency.
2. Low mood.
3. Homeless.

Discharge Medication:
Diazepam 5mg twice daily for one week only
Thiamine Hydrochloride tablets 300mg once daily for three months
Vitamin B Co-Strong two tablets three times a day for one week

Management:
1. Refer to Moving Into Health Team.
2. Given information on WLDAS.
3. Advised to self-refer to Combat Stress, although it was not clear as to whether James was actually in the Army or not.
4. We had planned to see James on the week following discharge, however, he has re-attended to A & E/Observation ward several times in the last week and has had a number of psychiatric assessments, therefore no further follow up recommended at this point.

Mr Weir was admitted to Ward 17 on an informal basis after presenting to A & E with low mood. He reported that he had several years of feeling low in mood, but over the past six months had become increasingly agitated, jumpy, argumentative, with decreased appetite, energy and sleep. In addition to this he had increased suicidal ideation, he felt that he was at risk of killing himself. He reported that his brother committed suicide two months ago on return from the Army and his mother had died last week from cancer. He is also experiencing flashbacks to an alleged sexual abuse that took place when he was 17 years old, because of this he tried to avoid social situations. However, he did report that he copes okay living in an all male mess in the Army.

Cont./...

Personal History:
James was born in Paisley and lived with his parents for the first few years. He reported physical abuse from his mum and he was on the Child Protection Register and put in care. He has two sisters. His parents split when he was aged 7 and both mum and dad remarried. He reports that the abuse went on until age 18 and he was therefore in a children's home from the ages of 12 to 16. He reports that his sisters were in the home as well but they were separated. He went to mainstream school but reports he had ADHD and was bullied. He did, however to get A Levels. When he left school he got an apprenticeship in Engineering and worked on the ships for the Army and then applied to the Army where he has worked for two years. He reports that his dad is in prison for rape.

Social History:
James currently lives with his sister, however he is now homeless after an argument with this sister earlier today. He reports he is on extended sick leave/compassionate leave from the Army. He reports that he is based in Catterick and has never been deployed. He recently separated from his partner who is due a baby in eight weeks.

Past Medical History:
Alcohol excess. Gastritis caused by chronic alcohol. Scarring of the liver due to chronic alcohol use.

Past Psychiatric History:
James reports that he was diagnosed with ADHD at the age of 4, however this was through in Glasgow and we have no record of this. He reports several overdoses in the past.

Forensic History:
James has been in prison as a teenager for theft and for carrying a knife.

Drug History:
Omeprazole.

Alcohol & Drug Use:
James is currently drinking three bottles of buckfast daily which he has been doing for the last six months. He reports that he drinks this four to five days of the week. He reports that he vomits if he does not have alcohol. He started to smoke cannabis occasionally 18 months ago and 3 months ago he has increased his cannabis use to daily, however he is unable to quantify exactly how much he is using.

On admission I found James to be appropriate dressed, unshaven but had reasonable eye contact. His speech was quiet and monotone but no evidence of formal thought disorder. In terms of his mood objectively I found him to be dysthymic with a blunted affect. In terms of abnormal thoughts he described some features of PTSD related to a sexual abuse claim seven years previously. He also reports that he is paranoid of others but denies any real auditory or visual hallucinations. His insight was intact.

Progress on the Ward:
James was a patient on the ward for approximately one week. During this time he failed to engage with activities on the ward and was found to be drinking alcohol and smoking cannabis whilst an inpatient. In addition to this whilst an inpatient and under the influence of alcohol James took a Paracetamol overdose that required him to be transferred to the Medical ward for treatment with N-Acetylcysteine.

Cont./...

It also transpired through the course of his stay that much of the history James had given on admission was doubtful. His sister reported that his mother had not in fact died and was still very much alive. She also reported that James is not in the Army and never had been in the Army. James also gave several contradictory pieces of information regarding his time in the Army and the abuse as a child and it was unclear exactly what was true and what was not true.

James was eventually discharged with a referral to the Moving Into Health Team, a referral to Alcoholics Anonymous and suggested to him that he could self-refer to the Combat Stress Team regarding the distress he was being caused about his time in the Army. Initially, the plan had been for James to be reviewed in the outpatient clinic a week following discharge, however James re-attended A & E on three to four occasions with suicidal ideation and requesting admission in the days following admission. Each time he underwent further psychiatric assessment and he was reassured that admission was not required as it failed to keep him safe and was in fact detrimental. Each time he was advised to engage with the Moving Into Health Team as well as Alcoholics Anonymous, however James reported that he now plans to move to Glasgow to live with his brother and therefore would not like follow up here. Should James stay in the area and you feel that he requires further psychiatric assessment, please do not hesitate to re-refer him.

Yours sincerely

Dr Laura Tweedie
GPST2 to Dr Shankar

NHS
Lothian

NUTRITIONAL SCREENING USING MUST

78200 SJ Pepper

201009798X M 12/03/1989
Weir, James T
28 Peveril Rise,
Livingston,
West Lothian,
EH54 6NU
CHI 1203893450
78260 SJ Pepper

Score 0 — **LOW RISK**; Routine Clinical Care
Repeat screening in 7 days

Score 1 — **MEDIUM RISK**; Observe
Steps A – F see over

Score 2 or more — **HIGH RISK**; Treat
Refer to Dietitian

DATE	WT (KG)	HT (M)	BMI (kg/m^2)	MUST SCORE	SCORE 0 LOW RISK *Routine Clinical Care*	SCORE 1 MEDIUM RISK *Observe*	SCORE 2 or more HIGH RISK *Treat*	SIGNED
				e.g. 1+1+0=2	Repeat screening in $^7/_7$	A – F see over	Refer to Dietitian	
17/1/13	62.3	1.75	20.3	1+0+0=1	✓			A Wilson

Food, Fluid, Nutrition (FFN) CQI Data

1) **Known food allergies Y N Allergy to:-** .....

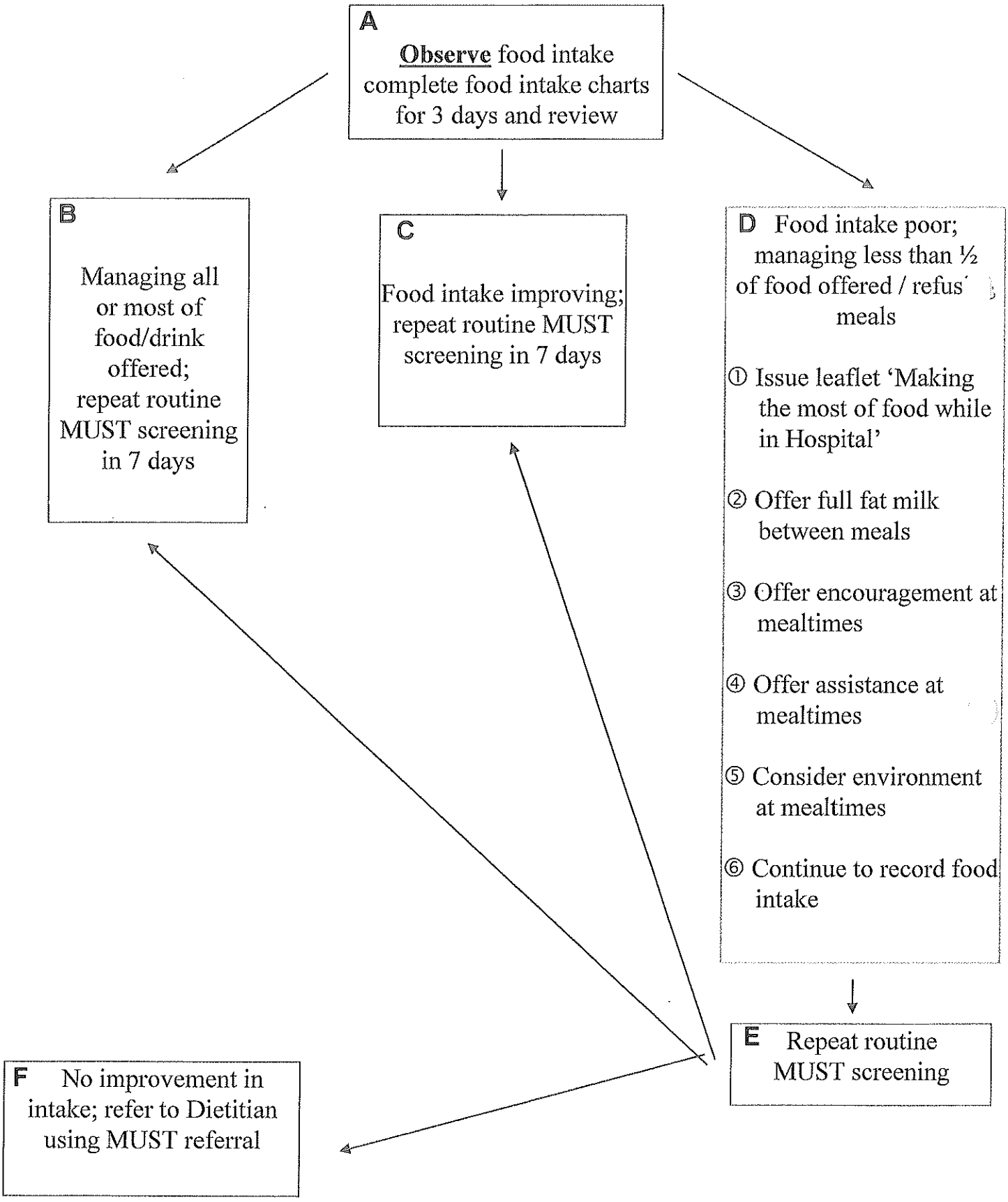
2) **Specific Dietary Needs Y N (e.g Vegetarian / Diabetic / Religious Diet)**

Please state:- .....

3) **Assistance required to meet dietary/hydration needs:- Y N**

NHS
Lothian

MEDIUM RISK SCORE 1



CHLORDIAZEPOXIDE REDUCING DOSE CHART

NHS Lothian

Name: JAMES WEIR	DoB 13.12.59	Ward 17	Unit No.	Consultant SKANKAR

Day	Date	Drug	Dose	Route	Administration Times Given by (initials *) 8am	1pm	6pm	10pm	Prescriber's Signature
1	19-7-13	Chlordiazepoxide	20mg	Oral	√ *	√ * VB	√ * VB	√ * DH	
2	20-7-13	Chlordiazepoxide	10mg	Oral	√ * DM	√ * AK	√ * KL		
		Chlordiazepoxide	20mg	Oral				√ * RF	
3	21-7-13	Chlordiazepoxide	10mg	Oral	√ * KL (7)	√ * DM	√ * AK	√ * SF	
4	22-7-13	Chlordiazepoxide	10mg	Oral	√ *	√ *		√ *	
5	23-7-13	Chlordiazepoxide	10mg	Oral	√ *			√ *	
6	24-7-13	Chlordiazepoxide	10mg	Oral				√ *	

PRESCRIBE **On main prescription sheet:** chlordiazepoxide according to reducing dose chart
and chlordiazepoxide 10 or 20mg as required (including maximum dose in 24 hours); review use daily

CONSIDER	**Prophylaxis of Wernicke-Korsakoff syndrome:**	1 pair IM or IV ampoules Pabrinex® daily for 3 days
	Treatment of Wernicke's encephalopathy:	1 pair IM or IV ampoules Pabrinex® twice daily for 2 days If symptoms respond ⇒ continue 1 pair ampoules daily for a further 3 days If no response ⇒ discontinue and consider referral to a neurologist
OR	**If no indication for parenteral supplementation:**	Thiamine orally 100mg three times daily for 5 - 7 days, then review

Please see reverse for further guidance on use of vitamins

GUIDELINES ON THE USE OF VITAMINS FOR PATIENTS REQUIRING ALCOHOL DETOXIFICATION

Alcohol dependent patients are at risk of developing **Wernicke-Korsakoff syndrome** due primarily to severe deficiency of the water-soluble vitamin B_1 (thiamine). Vitamin supplementation should be considered in **all** patients requiring alcohol detoxification. There is considerable doubt regarding the effectiveness of oral vitamin replacement because of limited absorption. It has also been shown that oral supplementation has little or no effect on CNS vitamin status, whereas parenteral replacement is rapidly effective.

DETECTION OF "AT RISK" PATIENTS

Clinical pointers to an increased risk include recent diarrhoea, vomiting, poor diet, other physical illness or signs of weight loss or malnutrition. The patient has probably been consuming more than 20 units of alcohol per day.
Prophylactic doses of high potency vitamins (Pabrinex®) **must** be prescribed.
(see overleaf)

DIAGNOSIS OF WERNICKE'S ENCEPHALOPATHY

A diagnosis of Wernicke's encephalopathy should be considered if a patient undergoing detoxification has **any** of the following signs: confusion; ataxia; ophthalmoplegia/nystagmus; memory disturbance; hypothermia and hypotension; coma/unconsciousness.
Treatment doses of high potency vitamins (Pabrinex®) **must** be prescribed.
(see overleaf)

USE OF ORAL VITAMINS

Absorption of oral vitamin B_1 (thiamine) appears to be independently reduced by both alcohol and malnutrition. Nevertheless, some thiamine may be absorbed and oral thiamine should be considered on an individual basis.
The recommended dose of thiamine is 100mg three times a day for 5 - 7 days, then review.

Pabrinex® Intramuscular High Potency (IMHP)

The intramuscular route is preferred and is recommended where muscle bulk allows.

The contents of each pair of ampoules (total 7mL) are drawn up into a syringe to mix them just before use, then injected high into the gluteal muscle, 5cm below the iliac crest. Administer over 3 to 5 minutes, and massage after injection.
Nurses may administer Pabrinex® by the intramuscular route.

Pabrinex® Intravenous High Potency (IVHP)

The preferred method for intravenous administration is by drip infusion. The contents of each pair of ampoules (total 10mL) should be diluted with 50 to 100mL sodium chloride 0.9% and infused over 15 to 30 minutes. Where glucose infusion is clinically indicated, glucose 5% can be used as the diluent. Alternatively the contents of each pair of ampoules (total 10mL) are drawn up into a syringe to mix them just before use, then injected slowly into a vein, over a period of 10 minutes.
If Pabrinex® is to be administered intravenously, a doctor must carry this out.

ANAPHYLAXIS

Repeated injections of preparations containing high concentrations of vitamin B_1 (thiamine) may give rise to anaphylactic shock. Mild allergic reactions such as sneezing or mild asthma are warning signs that further injections may lead to anaphylactic shock.
Parenteral vitamin supplements must only be administered where suitable resuscitation facilities are available and epinephrine (adrenaline) 1 in 1000 (1mg in 1mL) for intramuscular administration is readily available.

Adapted from LPCT Medicines Bulletin No. 8 (December 1999)
Wernicke-Korsakoff Syndrome – A Guideline: The use of vitamins B and C injection (Pabrinex®) for patients admitted for alcohol detoxification.

NHS
Lothian

WARD 17 SJH

NURSES DISCHARGE LETTER

Date 24/7/13	Key Worker:- Corina/Tracey
Name of Patient:- JAMES WELR	DOB:- 12-03-89.
Address:- 28 Peverl Rise, Livingston.	
Post Code:- EH54 6NU.	
Reason For Admission:- suicidal ideation - low mood.	
Date of Admission:- 17/7/13	Date of Discharge:- 24/7/13.
Discharge Summary:- - Discharged today with support from [redacted] (Homeless assessment officer) moving into health - keen to engage in AA - Advice given re recovery drop in	
Patient on Clozapine: Yes (No)	
Patient on Depot: Yes (No)	

IDL to be sent to:-	Patient Consent Y/N	Sent via Fax/Email/Post
COT/CPN		
ADDICTIONS/WLDAS		
OTHER		

Ward 17

Admission Checklist

CHI 1203893450
78260 SJ Pepper
201009798X M 12/03/1989
Weir, James T
28 Peveril Rise,
Livingston,
West Lothian,
EH54 6NU
CHI 1203893450

		Date done (or N/A)	Signature
1.	Orientate to ward environment	18/7/13.	AW
2.	Inform of Key worker system	18/7/13.	AW
3.	Give welcome pack	18/7/13.	AW
4.	Inform of ward routine, meal times, medication, visiting times etc	18/7/13.	AW
5.	Inform of observation policy	18/7/13.	AW
6.	Inform of current tobacco policy	18/7/13.	AW
7.	Inform of drugs & alcohol policy	18/7/13.	AW
8.	Obtain patient's medication for safekeeping	18/7/13.	AW
9.	Inform of chaplaincy services	18/7/13.	AW
10	Clarify legal status	18/7/13.	AW
11.	Inform of independent advocacy service	18/7/13.	AW
12.	Inform Ward Clerk of admission		
13.	Inform significant others of admission		
14	Inform CPN of admission (telephone or email)		
15	Inform Social Worker of admission		
16.	Inform support worker of admission		

Admitting Nurse (Print Name): A Wilson **Signature:** A Wilson

WARD 17

DISCHARGE CHECKLIST

	INITIAL WHEN DONE
Check and return any cash	JR
Check and return any valuables	CF
Check and return any belongings	CF
Check and clean bedspace/change bed	CF
Complete Discharge Letter	CF
If patient on Clozapine - ward clerk to take original kardex to OPD5	N/A
If patient on depot - contact continuing care clinic and arrange suitable handover of original kardex	N/A
Provide Patient with Satisfaction Questionaire	CF
Enter on Daily Returns sheet	CF
Remove any unwanted medication from trolley	CF
Final entry made into Nursing notes	CF
Remove name from boards	CF
Give nursing folder to ward clerk	CF

Observation Chart

NHS Lothian

Consultant: Dr Shankar

Date chart commenced: 22/7/13

This is chart number (1) **this admission**

Actual or estimated patient weight 62-3. **kgs**

ASU:

78260 SJ Pepper
201009798X M 12/03/1989
Weir, James T
28 Peveril Rise,
Livingston,
West Lothian,
EH54 6NU
CHI 1203893450

An Early Warning Score (SEWS) must be calculated every time patient observations are recorded. If SEWS score 4 or more then call the appropriate doctor and nurse in charge using the guidelines below. Increased frequency of observations (minimum hourly) should be commenced and a detailed report in the patient's medical notes should be completed.

Early Warning Score 4 or more
or concern with a patients condition.

↓

Call Junior Doctor & Senior Nurse/Nurse Practitioner
If Dr cannot attend within 20 mins, they should arrange a Deputy.

↓

Practitioner/Dr unable to attend within 20 mins **or** SEWS increased by 2 **or** patient deteriorating.

↓

Call appropriate SHO/Registrar & Senior Nurse/Nurse Practitioner

↓

Dr unable to attend within 10 mins **or** SEWS increased by 2 **or** patient deteriorating.

↓

Call appropriate Registrar/Consultant
Consider ICU referral/review of treatment plan

Early Warning Score 6 or more
or rapidly deteriorating patient.

↓

Call appropriate SHO/Registrar & Senior Nurse/Nurse Practitioner

Persistent Pain – 6 or above and unresponsive to guidelines

↓

Call Medical Staff/Senior Nurse/Nurse Practitioner

↓

For further advice contact:

ACUTE
Mon- Fri: **Bleep Acute Pain Team**
Out of hours: **On-call anaesthetist**

CANCER-RELATED
Mon- Fri: **Bleep Palliative Care Team**
Out of hours: **via switchboard**

Reorder Ref: WLT1016-Rev. 05/07

How to calculate SEWS Score

- **Do not add pain score to SEWS Score.**
- Record standard observations (RR, SpO_2, Temp, BP, HR, AVPU).
- Note whether observation falls in shaded "At Risk Zone". Score as per SEWS key.
- Add points scored and record total "SEWS Score" in bottom row of chart.
- Action as per guidelines on front of chart.

If RR >24	Review patient / CXR +/- gases / PEF (Peak Expiratory Flow) etc → Definitive Therapy			
If SpO_2 sats <93%	Review probe ? accurate Review patient → prescribe oxygen on drug chart if indicated, consider ABGs.			
If Temp >38	Blood cultures Other cultures Early antibiotic therapy if sepsis suspected.			
If Systolic BP<100	Review monitoring *(cardiac / oximetry / urine output / invasive BP etc).* IV Access Review patient / drug kardex.			
Consider:	IV fluid bolus and reassess. TREAT UNDERLYING CAUSE			
Consider:	Hypovolaemia	Obstructive	Distributive	Cardiac
	Dehydration	*PE*	*Sepsis*	*Arrhythmia*
	Blood loss	*Tamponade*	*Anaphylaxis*	*Pump failure*
If Pulse >130	Review monitoring *(cardiac monitor indicated)* IV Access Review patient / ECG / electrolytes → Definitive Therapy			
If responds to pain only or unresponsive	Assess airway, BM, GCS, neuro observation chart, review patient / kardex.			
If BM <4	Give Oral Carbohydrate / IV Dextrose. Consider checking urgent laboratory blood glucose.			

Pain Assessment & Management Guidelines

How to score pain:

Cancer-related pain: **Always** score **worst** pain in last 24 hours or since last assessment.
Acute pain: Score **current** pain on movement e.g. deep breathing

Pain Score:		Action:
0	**NONE**	Continue to assess pain with every set of observations **(must be** at least daily).
1-3	**MILD**	Continue to assess pain with every set of observations **(must be** at least daily).
4-5	**MODERATE**	Assess. Using guidelines, prescribe/give analgesia as appropriate for the patient. Review.
6-10	**SEVERE**	Assess. Using guidelines, prescribe/give analgesia as appropriate for the patient. Review.

PERSISTENT SEVERE PAIN (6 OR ABOVE), WHICH DISTRESSES THE PATIENT: REFER. SEE FLOW CHART OVER.

Lothian Guidelines

Cancer-related pain: Initiate Edinburgh Pain Assessment Tool (EPAT©) for pain score of 4 or above.
Use Palliative Care Guidelines.
Acute pain: Use Acute Pain Guidelines.

Nausea Score (0-3)

0 = **No Nausea**
1 = **Nausea** (consider anti-emetic)
2 = **Nausea/Vomiting** (administer anti-emetic)
3 = **Persistent Nausea &/or Vomiting** (contact Dr).

PERSISTENT NAUSEA &/OR VOMITING: USING GUIDELINES PRESCRIBE/GIVE ANTI-EMETICS. REVIEW.

SEWS KEY 0 1 2 3								
DATE:		18/7/13	22/7/13	22/7/13	22/7/13	22/7/13	22/7/13	23/7/13
TIME:		23⁰⁰	17³⁰	21²⁰	22-20	23.20	00.20	02.20
RESP. RATE	≥36							
	31-35							
	21-30							
	9-20		18					
	≤8							
SpO_2	≥93							
	90-92			96%	96		97	
	85-89							
	<85							
Inspired O_2%	%							
Humidifier Temp								
TEMP	>39° / 38° / 37° / 36° / 35° / 34°	36.6	36.7	36.6		35.8	36.3	36.2
SEWS SCORE uses Systolic BP — BLOOD PRESSURE	210–50	116/67	108/58	96/53	83/40	81/41	97/53	82/40
HEART RATE	>140–30	73	90	92	78	69	63	62
SEDATION / NEURO SCORE	S Sleep							
	0 Alert			✓				
	1 Verbal							
	2 Pain							
	3 Unresp							
UO<30mls/hr (3 hrs+)								
SEWS SCORE (with all obs)								
PAIN Severe	9-10							
	6-8							
Moderate	4-5							
Mild	1-3							
None	0							
Nausea Score (0-3)								
BM								
Weight								
Bowels								
Drain Type –								
Wound								
Circulation								
Sensation								
Movement								

PRESCRIBERS

1. **USE GENERIC NAME**, write in **BLOCK LETTERS**.*
2. As Required Prescriptions shall include the Symptoms to be Relieved, the Minimum Time Interval and the Maximum Daily Dose.
3. Write doses of less than 1mg as micrograms e.g. 500 micrograms; Units and Nanograms should be written in full.
4. When a prescription line is completed a new chart should be written. Additions, overwriting and continuation on a lower part of the chart are **NOT** allowed.
5. Discontinue a medicine by clearly crossing out the prescribing side and administration record, **SIGN** and **DATE** discontinuation.
6. Medicine Sensitivities box should be completed and signed by Authorised Staff.
7. Verbal orders must be countersigned by the prescriber within 24 hours or the prescription will lapse.
8. Only **APPROVED** abbreviations should be used on this chart.
9. **All prescribers should ensure they are familiar with their responsibilities as set out in the NHS Lothian Safe Use of Medicines Policy.**

NURSES

1. Check ward name, patients name and CHI number are filled in correctly.
2. Check entries in every section to avoid omissions.
3. Nurses initials should be recorded in **BLOCK LETTERS**.
4. When a medicine is not given, then the reason for omissions should be recorded in the administration boxes as per codes on front of Medicine Chart.
5. Administration should be carried out in accordance with NMC Guidelines (as amended) and the **NHS Lothian Safe Use of Medicines Policy.**

* *Remember that certain medications should be prescribed by brand name e.g. Lithium, Diltiazem. Refer to BNF for advice.*

STAFF IN ANY DOUBT ABOUT ANY ASPECT OF DRUG THERAPY OR POLICY RELATING TO THE USE OF MEDICINES, CONTACT YOUR PHARMACIST OR PRESCRIBER

LEAVE MEDICATION REQUEST

DATE	START DATE/TIME	RETURN DATE/TIME	AS REQUIRED/MEDS	REQUESTED BY	PHARMACY	GIVEN OUT BY

DEPOT PRESCRIPTION

Start Date	Depot Injections (IM)	Dose	Frequency									
Start Date	Depot Injections (IM)	Dose	Frequency	Date								
Prescriber sign + print		Stop Date & Initials		Given By								
Start Date	Depot Injections (IM)	Dose	Frequency	Date								
Prescriber sign + print		Stop Date & Initials		Given By								
Start Date	Depot Injections (IM)	Dose	Frequency	Date								
Prescriber sign + print		Stop Date & Initials		Given By								
Start Date	Depot Injections (IM)	Dose	Frequency	Date								
Prescriber sign + print		Stop Date & Initials		Given By								
Start Date	Depot Injections (IM)	Dose	Frequency	Date								
Prescriber sign + print		Stop Date & Initials		Given By								
Start Date	Depot Injections (IM)	Dose	Frequency	Date								
Prescriber sign + print		Stop Date & Initials		Given By								
Start Date	Depot Injections (IM)	Dose	Frequency	Date								
Prescriber sign + print		Stop Date & Initials		Given By								

Affix Photogr

78260 SJ Pepper
201009798X M 12/03/1989
Weir, James T
28 Peveril Rise,
Livingston,
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EH54 6NU
CHI 1203893450

MEDICINE CHART

Ward: 17

Chart No: (1)

Consultant: Shankar

Date of Admission: 17/7/13

Weight on Admission:

Age:

NHS Lothian

Mental Health Services

CODES FOR NON-ADMINISTRATION OF PRESCRIBED MEDICINE

If a dose is not administered as prescribed, then enter a code in the column with a circle drawn around the entry according to the reason, as follows:

Patient refuses	1	Vomiting/nausea	9
Patient not present on ward	2	Time varied on Dr's instructions	10
Medicine not available	3	Once only/PRN medication given	11
Instructions not clear or legal	4	Medicine not required	12
Patient Self-Administered Medicine	5	Pass medication given	13
Nil by mouth	6	Medicine spat out	14
Asleep/drowsy	7	Part dose only taken	15
Unable to swallow	8	Medicine Withheld	16

OTHER CHARTS IN USE

Please ✓ Box	
Detoxification	
Clozapine	
Anticoagulant	
Diabetic	
Other *(Specify)*	

MEDICINE SENSITIVITIES

Signature:

Date:

HIGH DOSE MONITORING APPLICABLE

YES / NO	Start Date:
	Stop Date:
Signature:	Date:

Adults with Incapacity (Scotland) Act 2000 Applicable

YES / NO

Expiry Date:

Name of Welfare Guardian:

Mental Health (Care and Treatment) (Scotland) Act 2003

Consent to Treatment Form T2 / T3? YES / NO

* If YES, check treatment plan details before prescribing *

ONCE ONLY

Date	Time	Pharmacy	Medicine (Approved Name)	Dose	Route	Prescriber sign + print	Time Given	Given by	Checked by
18/7/13	2345.		Pabrinex	2x(I+II)	IV	LT	0005	ES	OM
19-7-13	1045		CHLORDIAZEPOXIDE	20mg	Po	[signature]			
19/7/13	2255		PEPTAC		ORAL		2255	DV	

DEPOT ADMINISTRATION See back page for Prescription details

REGULAR PRESCRIPTIONS

Patient's Name: James Weir
CHI No: 1203893650 DoB:

Medicine (Approved Name): Fabrazyme
Dose: 2 x (1+11)
Route: IV
Prescriber sign + print: LT
Additional Information: 3 DAYS.
Date: 18/7/13.
Valid Period:
Stop Date & Initials:
Pharmacy:

Enter Date → Circle Times Req.	Date	19/7	20/7/13	21/7/13	22/7	Date
(08:00)		LT	NC	LO		
13:00						
18:00						
(22:00)	X	NC.	AR			

Medicine (Approved Name): CHLORDIAZEPOXIDE REDUCING REGIME
Dose: AS
Route:
Prescriber sign + print: Shanen
Additional Information:
Date: 19/7/13
Valid Period:
Stop Date & Initials:
Pharmacy:

Enter Date → Circle Times Req.	Date	19/7	20/7/13	21/7/13	22/7	Date
08:00						
13:00		VA	AK	KR	TW	
18:00		VO	KR	AK	X	
22:00			RF	SSB	X	

Medicine (Approved Name): Vit B Co Strong
Dose: /TT
Route: o
Prescriber sign + print: K Waller
Additional Information: one week only
Date: 22/7/13
Valid Period:
Stop Date & Initials:
Pharmacy:

Enter Date → Circle Times Req.	Date	19/7	20/7/13	21/7/13	22/7	Date
(08:00)						
(13:00)						
18:00						
(22:00)					RF	

Medicine (Approved Name): DIAZEPAM
Dose: 5mg
Route: o
Prescriber sign + print: K Waller
Additional Information: one week only
Date: 22/7/13
Valid Period:
Stop Date & Initials:
Pharmacy:

Enter Date → Circle Times Req.	Date	19/7	20/7/13	21/7/13	22/7	Date
(08:00)						
13:00						
18:00						
(22:00)					RF	

Medicine (Approved Name): THIAMIN
Dose: 300mg
Route: o
Prescriber sign + print: K Waller
Additional Information: for 3 months
Date: 22/7/13
Valid Period:
Stop Date & Initials:
Pharmacy:

Enter Date → Circle Times Req.	Date	19/7	20/7/13	21/7/13	22/7	Date
(08:00)						
13:00						
18:00						
22:00						

Medicine (Approved Name):
Dose:
Route:
Prescriber sign + print:
Additional Information:
Date:
Valid Period:
Stop Date & Initials:
Pharmacy:
08:00
13:00
18:00
22:00

Medicine (Approved Name):
Dose:
Route:
Prescriber sign + print:
Additional Information:
Date:
Valid Period:
Stop Date & Initials:
Pharmacy:
08:00
13:00
18:00
22:00

Medicine (Approved Name):
Dose:
Route:
Prescriber sign + print:
Additional Information:
Date:
Valid Period:
Stop Date & Initials:
Pharmacy:
08:00
13:00
18:00
22:00

Medicine (Approved Name):
Dose:
Route:
Prescriber sign + print:
Additional Information:
Date:
Valid Period:
Stop Date & Initials:
Pharmacy:
08:00
13:00
18:00
22:00

Medicine (Approved Name):
Dose:
Route:
Prescriber sign + print:
Additional Information:
Date:
Valid Period:
Stop Date & Initials:
Pharmacy:
08:00
13:00
18:00
22:00

Date Date Date Date Date Date

Name:
DoB:

	Date
x in 24h	Time
rmacy	Dose
ls	Given by
	Date
x in 24h	Time
rmacy	Dose
ls	Given by
	Date
x in 24h	Time
rmacy	Dose
ls	Given by
	Date
x in 24h	Time
rmacy	Dose
ls	Given by
	Date
x in 24h	Time
rmacy	Dose
ls	Given by

Exceptions
Prescriber sign + print

Route	Time	Given By	Date	Medicine	Dose	Route	Time	Given By
o	1430	TW						

REGULAR PRESCRIPTIONS

Patient's Name: James Weir
CHI No: 1203893650 DoB:

Enter Date
Circle Times Req.

Medicine (Approved Name) Fabrney	Dose 2 x (1+II)	Prescriber sign + print LT	[✓ 08:00]
	Route IV	Additional Information 3 DAYS.	13:00 18:00
Date 18/7/13. / Valid Period	Stop Date & Initials	Pharmacy	[✓ 22:00]

Medicine (Approved Name) CHLORDIAZEPOXIDE REDUCING REGIME	Dose AS	Prescriber sign + print Shanen	08:00
	Route	Additional Information	13:00 18:00
Date 19/7/13 / Valid Period	Stop Date & Initials	Pharmacy	22:00

Medicine (Approved Name) VitBCo Strong	Dose I/II	Prescriber sign + print K Waller	[✓ 08:00]
	Route o	Additional Information one week only	[✓ 13:00] 18:00
Date 22/7/13 / Valid Period	Stop Date & Initials	Pharmacy	[✓ 22:00]

Medicine (Approved Name) DIAZEPAM	Dose 5mg	Prescriber sign + print K Waller	[✓ 08:00]
	Route	Additional Information one week only	13:00 18:00
Date 22/7/13 / Valid Period	Stop Date & Initials	Pharmacy	[✓ 22:00]

Medicine (Approved Name) THIAMIN	Dose 300mg	Prescriber sign + print K Waller	[✓ 08:00]
	Route o	Additional Information for 3 months	13:00 18:00
Date 22/7/13 / Valid Period	Stop Date & Initials	Pharmacy	22:00

Medicine (Approved Name)	Dose	Prescriber sign + print	08:00
	Route	Additional Information	13:00 18:00
Date / Valid Period	Stop Date & Initials	Pharmacy	22:00

Medicine (Approved Name)	Dose	Prescriber sign + print	08:00
	Route	Additional Information	13:00 18:00
Date / Valid Period	Stop Date & Initials	Pharmacy	22:00

Medicine (Approved Name)	Dose	Prescriber sign + print	08:00
	Route	Additional Information	13:00 18:00
Date / Valid Period	Stop Date & Initials	Pharmacy	22:00

Medicine (Approved Name)	Dose	Prescriber sign + print	08:00
	Route	Additional Information	13:00 18:00
Date / Valid Period	Stop Date & Initials	Pharmacy	22:00

Medicine (Approved Name)	Dose	Prescriber sign + print	08:00
	Route	Additional Information	13:00 18:00
Date / Valid Period	Stop Date & Initials	Pharmacy	22:00

AS REQUIRED PRESCRIPTIONS

Patient's Name:
CHI No: DoB:

Medicine		Indication		Date
Dose	Route	Frequency	Max in 24h	Time
Prescriber sign + print		Date	Pharmacy	Dose
Additional Information		Stop date & initials		Given by

Medicine		Indication		Date
Dose	Route	Frequency	Max in 24h	Time
Prescriber sign + print		Date	Pharmacy	Dose
Additional Information		Stop date & initials		Given by

Medicine		Indication		Date
Dose	Route	Frequency	Max in 24h	Time
Prescriber sign + print		Date	Pharmacy	Dose
Additional Information		Stop date & initials		Given by

Medicine		Indication		Date
Dose	Route	Frequency	Max in 24h	Time
Prescriber sign + print		Date	Pharmacy	Dose
Additional Information		Stop date & initials		Given by

Medicine		Indication		Date
Dose	Route	Frequency	Max in 24h	Time
Prescriber sign + print		Date	Pharmacy	Dose
Additional Information		Stop date & initials		Given by

Date	**SYMPTOMATIC RELIEF POLICY**	Exceptions	Prescriber sign + print

Date	Medicine	Dose	Route	Time	Given By	Date	Medicine	Dose	Route	Time	Given By
20/7	Peptac	10mg	O	1430	TM						

AS REQUIRED PRESCRIPTIONS

Patient's Name:

CHI No: DoB:

Medicine: Lorazepam		Indication: AGITATION		Date	20/7/13	21/7/13	22/7/13
Dose: 2mg	Route: oral	Frequency: 1°	Max in 24h: 8mg	Time	0140	0006	2255
Prescriber sign + print: [illegible]		Date: 18/7/13	Pharmacy	Dose	2mg	2mg	1mg
Additional Information		Stop date & initials		Given by	DM	SA	SA

Medicine: Haloperidol		Indication: AGITATION		Date			
Dose: 5mg	Route: oral	Frequency: 1°	Max in 24h: 30mg	Time			
Prescriber sign + print: [illegible]		Date: 18/07/13	Pharmacy	Dose			
Additional Information		Stop date & initials		Given by			

Medicine: diazepam		Indication: WITHDRAWAL		Date	19/7/13	19/7/13	
Dose: 5mg	Route: oral	Frequency: 1°	Max in 24h: 30mg	Time	1000	2315	
Prescriber sign + print: [illegible]		Date: 18/07/13	Pharmacy	Dose	5mg	5mg	
Additional Information		Stop date & initials		Given by	AW	[illegible]	

Medicine: CHLORDIAZEPOXIDE		Indication: Agitation/withdrawal		Date	20/7/13		
Dose: 10mg	Route: PO	Frequency	Max in 24h	Time	2005		
Prescriber sign + print: [illegible]		Date: 18.7.13	Pharmacy	Dose	10mg		
Additional Information		Stop date & initials		Given by	KR		

Medicine: PROCHLORPERAZINE		Indication: NAUSEA		Date			
Dose: 10mg	Route: po	Frequency: max TID	Max in 24h: 30mg	Time	No stemetil available		
Prescriber sign + print: [illegible] ROONEY		Date: 20/7/13	Pharmacy	Dose			
Additional Information: LIQUID		Stop date & initials		Given by			

Medicine: CYCLIZINE		Indication: NAUSEA		Date			
Dose: 50mg	Route: po	Frequency: max TID	Max in 24h: 150mg	Time			
Prescriber sign + print: [illegible] ROONEY		Date: 20/7/13	Pharmacy	Dose			
Additional Information		Stop date & initials		Given by			

Medicine		Indication		Date			
Dose	Route	Frequency	Max in 24h	Time			
Prescriber sign + print		Date	Pharmacy	Dose			
Additional Information		Stop date & initials		Given by			

Medicine		Indication		Date			
Dose	Route	Frequency	Max in 24h	Time			
Prescriber sign + print		Date	Pharmacy	Dose			
Additional Information		Stop date & initials		Given by			

Medicine		Indication		Date			
Dose	Route	Frequency	Max in 24h	Time			
Prescriber sign + print		Date	Pharmacy	Dose			
Additional Information		Stop date & initials		Given by			

AS REQUIRED PRESCRIPTIONS

Patient's Name:

CHI No: DoB:

West Lothian

Department of Psychiatry
St John's Hospital
Howden Road West
LIVINGSTON
EH54 6PP

201 009 798X FC

NHS
Lothian

West Lothian
Community Health and Care Partnership

Dr Walker
General Medicine
St John's Hospital

Date:	08 August 2013
Dictated:	31 July 2013
Our Ref:	AN/SH
CHI No:	1203893450
Enquiries to:	[redacted]
Extension:	53772
Direct Line:	01506 523772
Direct Fax:	01506 523780

Dear Dr Walker

RE: JAMES WEIR, 35 PYOTHALL COURT, BROXBURN EH52 6GX
DATE OF BIRTH: 12.03.89

Thank you for referring this patient for review by Liaison Psychiatry. I saw Mr Weir in Ward 9 on 29 July 2013. I subsequently discussed his case with Dr Kennedy, Consultant Liaison Psychiatrist, who suggested the following Impressions and Management Plan.

Impressions

1. Impulsive overdose of 32 Paracetamol tablets, 10 x 5mg Diazepam tablets and half a gram of Amphetamine shortly after being reviewed by psychiatry.
2. Recent discharge from Ward 17. Admission was not thought to be helpful as Mr Weir continued to use drugs and alcohol and took an overdose whilst being an inpatient.
3. Previous overdoses.

Suggested Management Plan

1. Home when medically fit.
2. Follow up as previously arranged. A referral has been made to "Moving Into Health".

Mr Weir is a 24 year old man who was admitted to hospital after taking an overdose of 16mg of Paracetamol, 50mg of Diazepam and half a gram of Amphetamine shortly after being reviewed by psychiatry with suicidal ideation. Mr Weir told me he took the overdose as it was the only way he could let his emotions out and that he wanted to end the pain in his life but he did not want to die. He recently had a short admission to Ward 17 but the ward environment was not thought to be helpful to him as he had continued to use alcohol and drugs and had taken a Paracetamol overdose whilst an inpatient on the ward.

Mr Weir has a several year history of low mood and self harm although he has not self harmed for the last 4 months. At my time of assessment he was requesting to be readmitted to Ward 17 and told me that he got in with the wrong people whilst on the ward who he contributed his actions to. He told me that the ward environment would be useful for him to try and get his head sorted and also named other patients from Ward 17 who he told me were also using drugs and alcohol whilst on pass.

Psychiatric History
ADHD
Previous overdoses

Past Medical History
Alcohol excess, alcoholic gastritis, alcoholic liver disease.

Personal and Social History
Mr Weir was born and brought up in Glasgow. He tells me he was physically abused by his mum and was placed on the child protection register and grew up partly in care. He told me he spent time in children's homes between the age of 12 and 16 due to behaviour issues. However, he managed in mainstream school. He tells me he has been in the army for the past 4 years and has served in Iraq and Afghanistan and he told me that he has been referred for combat stress through the army. He tells me he has been with his current partner for 12 years and they are expecting their first baby in 7 weeks time. His partner lives in Glasgow. Mr Weir lives alone in a council house in Broxburn. He is currently on sick leave from the army due to mental health issues. He has previously been in prison as a teenager for theft and carrying a knife. Mr Weir tells me he is drinking either 5 bottles of Buckfast a day or one litre of vodka a day and tells me that he gets withdrawal symptoms on cessation of drinking. He smokes Cannabis occasionally telling me the last time was around 2 weeks ago. He smokes 10 cigarettes per day.

Mental State Examination
Mr Weir was a 24 year old Caucasian gentleman with multiple tattoos and a missing front tooth. He was appropriately dressed at my time of assessment and maintained reasonable eye contact and rapport. His speech was normal and there was no evidence of thought disorder. Subjectively he described his mood as upset and frustrated and objectively although he seemed low in mood, he had a reactive affect. He described difficulties with his sleep and appetite and tells me he has lost 3 stones over the last 6 months. He denied any visual or auditory hallucinations and cognitively he was orientated to time, place and person.

There were inconsistencies in Mr Weir's personal history between what he told nursing staff and different members of the medical team. This was also the case during his recent admission to Ward 17. It was not felt that the ward environment was beneficial for Mr Weir and that he is best managed with support in the community, including a referral to "Moving Into Health" which was made whilst he was an inpatient. Mr Weir was very frustrated that he was not able to be admitted to the ward on this occasion and told me he would speak to his army medical officer about the situation. I have discussed the above with Dr Kennedy who agreed that further admission was unlikely to be beneficial and Mr Weir should be discharged from hospital once he was medically fit. Should you require any further information, please do not hesitate to contact me.

Yours sincerely

Dr A Nimmo
FY1 to Dr Kennedy
Liaison Psychiatry Team, St John's Hospital

Copy: Dr Pepper, Dedridge Medical Practice, Nigel Rise, Dedridge, Livingston
Dr Shankar

INITIAL ASSESSMENT

NHS Lothian

Date of assessment: 29 / 7 / 13

1. Personal details

Surname	201009798X M 12/03/1989
First name	**Weir, James T**
Preferred name	35 Pyothall Court,
CHI	Broxburn,
Date of birth	West Lothian,
MHI	EH52 6GX
Address	**CHI** 1203893450
	78260 SJ Pepper
Postcode:	201009798X
Telephone no:	

Sex:	Male / Female
Title:	
Surname at birth:	
Other previous surname:	
Ethnic group:	
1st language	
Interpreter required?	Yes / No
Occupation:	
Religion / beliefs:	
Address type:	Permanent / temporary
UK Resident last 12months:	Yes / No

2. GP details

GP	DR PEPPER
Practice	DEORIDGE MEDICAL GROUP
Practice address	
Postcode:	
Telephone no:	
Fax no	

3. Next of Kin

Is NOK the named person? Yes / No

Surname:	
First name	
Relationship:	
Address:	
Postcode:	
Telephone no:	

Alerts

(e.g. allergies, safety issues)

ICD 10 category

4. Legal status

MHA Section		Expiry date:
		Expiry date:
		Expiry date:
Advance statement	Yes / No	Where held:

5. Admission details

(Section 5 to be completed if admitted to hospital or other service)

Date of admission: ___ / ___ / ___	Ward/Service:
Time of Admission (24hr clock) :	Consultant:
Referred by:	key worker:

Medical records informed?: YES / No **(inpatient use only)**

Name:	CHI:	Date: ___ / ___ / ___

6 Details of those currently providing care

(e.g. CPN, consultant, social worker, OT, psychologist)

Name	Relationship / Role	Address / telephone number/ e mail

7. Details of significant others

(includes, **Named person (if different from NOK)**, carer, advocate and others that user wishes to be noted)

Name	Relationship / Role	Address / telephone number/ e mail

Ensure that you clarify <u>and record</u> below what type of information can be shared with whom and individual confirms with signature where possible

8. Assessor details

Time of assessment (24hr clock): 1500	Location of assessment: 4 9
Primary assessor: MLISH NIMMO	Designation: PYI
2nd assessor:	Designation:
Assessing team:	Referred by:
Factors affecting assessment (e.g. intoxication): BAC:	

9. Physical identifiers

General appearance:	Distinguishing features:	
Hair colour:	Height:	Build:
Eye colour:	Dentition:	

Name:	CHI:	Date: ___ / ___ / ___

10. History of presenting complaint

(24)* Discharged from Ward 17 24/7/13, had taken paracetamol OD whilst outside smoking
Seen 29/7 with suicidal ideation → d/c, admission not thought helpful
OD 32mg paracetamol Saturday evening + diazepam 10×5mg + ½gm amphetamine
'This is the only way I can get my emotions out' 'Want to end the pain in my life but I don't want to die'

Several year history of low mood + self harm, no self-harm for past 4 months

States that was with 'wrong people' on ward 17 - drugs + alcohol.
Wishing re-admission to ward, naming patients who had also drunk alcohol on ward and displaying frustration that they had not been discharged

Been told by medical doctors that high risk of further event / OD / suicide and angry that he is being sent home despite this

Person's view of current situation:

Wishes admission
'I want to get my head sorted'

Person's usual ways of coping and strengths:

Current crisis plan? Yes / No

Spiritual beliefs / needs:

Family history:

Brother committed suicide

Personal history:

Born + brought up in Glasgow
Physical abuse from mum - on child protection register, in care
Children's home age 12-16 due to behaviour
Managed in mainstream school.
Been with army for past 4 years (sniper) - been to Iraq + Afganistan
↳ Has been referred for combat stress.
Baby due 4 in 7 weeks - states still with partner, been with her for 12 years.
Partner lives in Glasgow.

Name:	CHI:	Date: ___ / ___ / ___

Social circumstances

Lives in Broxburn, lives alone, council house — forensic - kept in prison as remanded for theft + carrying knife.
On sick leave from Army - based in Catterick.

Past Medical History & current physical health:

Alcohol excess
Alcoholic gastritis
Alcoholic liver disease

Past Psychiatric history:

ADHD
Several ODs

Carer's view of current situation (including carer's usual role):

Does carer live at same address? Yes / No

Current medication (including over the counter medicines, note name, dosage, concordance)

Thiamine
Omeprazole
Vitamin B co-strong

Sources of information: service user / carer / GP / Pharmacist / Notes / Other

Alcohol use (note quantity):

5 bottles buckfast /day or 1L vodka /day
Drinking most days
States gets withdrawal sx.

Risk of dependence / withdrawal: Yes / No

Other substance use:

Cannabis - last smoked 2 weeks ago.

Prescribed opiate substitute? Yes / No If Yes: Details of who dispenses:

Risk of dependence / withdrawal: Yes / No

Risk of blood borne viruses: Yes / No Smoker: Never / Ex / Current: 10 per day

Name:	CHI:	Date: ___ / ___ / ___

11. Assessment

Current mental state

Appearance & behaviour

Appropriately dressed

Reasonable eye contact + rapport.

Speech, communication, any thought disorder

Speech (N)

No evidence FTD

Mood / affect (including sleep and appetite)

Mood (S) upset frustrated reactive

(O) dysthymic, blocked affect.

Sleep poor

Appetite poor lost 3 stone past 6 months

Thought content, abnormal beliefs, abnormal experiences

No visual/auditory hallucinations

Cognitive function

Orientated T/P/P

Insight, judgement

Wished ward if admission.

12. Risk Screening

Risk from others (e.g. abuse, exploitation, domestic violence) ☐ Yes ☐ No ☐ Unknown

GBV Routine Enquiry assessed: Yes ☐ No ☐ Data entered onto Pims: Yes ☐ No ☐

Further investigation required? ☐ Yes ☐ No By Whom?

Risk to self (e.g. suicide, self harm, driving) ☐ Yes ☐ No ☐ Unknown

Further investigation required? ☐ Yes ☐ No By Whom?

Name:	CHI:	Date: ___ / ___ / ___

12. Risk Screening continued

Risk to others (e.g. aggression, violence, driving, access to weapons, supervision failure) ☐ Yes ☐ No ☐ Unknown

Further investigation required? ☐ Yes ☐ No By Whom?

Risk of neglect (e.g. health, personal) ☐ Yes ☐ No ☐ Unknown

Further investigation required? ☐ Yes ☐ No By Whom?

Risk to children (e.g. neglect, abuse) ☐ Yes ☐ No ☐ Unknown

Is there a risk to children due to mental state? (e.g. child included in suicide plans, delusional thinking). **A consultant psychiatrist should be directly involved in all clinical decision making for service users who may pose a risk to children.**

Further investigation required? ☐ Yes ☐ No By Whom?

Risk of physical impairment (e.g. memory, sensory) ☐ Yes ☐ No ☐ Unknown

Further investigation required? ☐ Yes ☐ No By Whom?

Risks relevant to service providers ☐ Yes ☐ No ☐ Unknown

(e.g. risks to staff, circumstantial or environmental risks identified for visiting staff)

Further investigation required? ☐ Yes ☐ No By Whom?

Sources of information available / used: service user / carer / family / police / 3rd party / PiMS / TRAK / other

Is Level 2 Risk Assessment indicated? ☐ Yes ☐ No **Responsible team:**

Name:	CHI:	Date: ___ / ___ / ___

13. Summary & plan

Summary of assessment (inc. summary of risk assessment, current needs)

(24)+ 1) Impulsive OD paracetamol, diazepam, amphetamine
Shortly after being reviewed by psychiatry

2) Recent d/c ward 17
Admission not thought to be helpful - OD, drugs + alcohol whilst inpatient.

3) Previous ODs.

4) Fluctuating story

Formulation /diagnosis

Person's desired immediate outcome(s):

Is person medically suitable for admission to psychiatric inpatient care? Yes / No
Comment:

Management plan (inc. plan to manage identified risks)

Home when medically fit

F/u as before - referred to Moving Into Health.

Discussed with: Dr Kennedy

Referred to: CMHT / IHTT / In-patient service* / GP / other (specify): _____

***If referred to in-patient services – complete immediate needs form with service user and /or carer**

If referred to in-patient services- briefly detail what alternatives were considered and why these were not possible:

Assessor- Name/Grade:	Signature:	**Date:**
Nimmo FY1	Nilish Nimmo	29 / 7 / 13

O.P. CLINICAL NOTES

(Psychiatry)

NUMBER 201009798X M 12/03/1989

NAME **Weir, James T**
28 Peveril Rise,
Livingston,
West Lothian,
EH54 6NU

CHI 1203893450
78260 SJ Pepper

DATE | SHEET No.

7/8/13 Police referal
OPDS

Arrested police station
drunk - A&E → cells.
yesterday - drinking early
cider → breakfast
don't know how much
breathalyser →
I have alcohol problem
AA meetings - nice people - Sat + Sun. am
plans to return to Glasgow - family there pm
will be dad in 4 weeks. - in Paisley
Combat Stress → next week
need to stop drinking.
being given one more chance.
don't agree ↓ drugs
smoking cannabis on the wood.
mum died
sister said mum not dead → she's a shit stirrer.

sister wanted him d/c
ripped out his section
wants nothing to do → wants to return to Glasgow.

Lorraine Maclean - CPN - Moving into Health

discharge
no follow up

"It has to me that stops"

DNA risk
AT STAGE
CONSULTANT.

meds - trimipramine 300mg.
Vit B Comp x 2 tds.
diazepam - stopped.

West Lothian Council

Department of Psychiatry
St John's Hospital
Howden Road West
LIVINGSTON
EH54 6PP

NHS Lothian

West Lothian
Community Health and Care Partnership

Dr Pepper
Dedridge Health Centre
LIVINGSTON
West Lothian

Date: 8th August 2013
Date of dictation: 7th August 2013
Our Ref: AS/PG/
CHI No: 1203893450
Enquiries to: [redacted]
Extension: 53792
Direct Line: 01506-523792
Direct Fax: 01506-523780

Dear Dr Pepper

RE: JAMES WEIR 28 PEVRIL RISE DEDRIDGE EH54 6NU
DATE OF BIRTH: 12.03.1989

Diagnosis
Alcohol dependence

Medication
Thiamine 300 mg
Vitamin B Co-strong 2 tablets tds

Plan
Discharge from psychiatry

James was brought to OPD5 for psychiatric assessment by the police on the 7th August 2013. He was picked up the previous night intoxicated and saying he was suicidal. He was brought to St Johns Hospital for assessment but was too drunk and so spent the night in the cells. Jams recalled little of the yesterday's event as he had started drinking early in the morning. He couldn't tell me how much or how he ended up at the police station saying he was police officer. James was quick to acknowledge that he had an alcohol problem and *"it has to be me that stops"*. Following his discharge from the ward it seems that he has engaged with all the services that he was encouraged to. He attends AA meetings on a Saturday morning and Sunday evening and feels they this has been supportive. He has an appointment next week with Combat Stress. He has an appointment later today with CPN Lorraine McLean from Moving into Health. He told me he didn't agree with the drugs, but admitted that he had smoked Cannabis on the ward when I had put this to him. He said that he had got in with the wrong crowd. I put it to him that in the notes there was a query about whether or not he was telling the truth about his mother's death from cancer. He explained that his sister had told the staff on the ward that she wasn't dead because she is a *"shit stirrer"*. He explained that his sister wanted him discharged from the ward so he could help her look after her four year old. He describes her ripping out his venflon and phoning the police on him. He explained that she told the police he had broken into her house, but she had given him the key. James says he now wants nothing to do with her and plans to eventually return to Glasgow to be with his family there. He says his fiancée is due to have his baby in four weeks and he wants to be a part of this baby's life. James appeared to take responsibility for his health and wants desperately to stop drinking. He feels he has a lot to lose

and told me he plans to address his drinking problem. I found no evidence of depression or of a mental illness. He had no thoughts of harming himself or of ending his life. I have not arranged further psychiatric follow up.

Yours sincerely

Dr Amal Al Sayegh
Consultant Psychiatrist

Cc: Lorraine McLean, Moving into Health

Department of Psychiatry
St John's Hospital
Howden Road West
LIVINGSTON
EH54 6PP

2010097798X

West Lothian Council

NHS Lothian

West Lothian
Community **H**ealth and **C**are **P**artnership

Dr Pepper
General Practitioner
Health Centre
Dedridge

Date: 15/08/13
Dictated: 13/08/13
Our Ref: SK/eb
CHI No: 1203893450
Enquiries to: [redacted]
Extension: 53772
Direct Line: 01506 523772
Direct Fax: 01506 523780

Dear Dr Pepper

RE: JAMES WEIR, 35 PYOTHALL COURT, BROXBURN. EH52 6GX
DOB/CHI 12/03/89 3450

Date & Venue:
13th August 2013. Medical Assessment Unit, St John's Hospital.
Dr Sarah Kennedy, Consultant Liaison Psychiatrist.

Purpose of Review:
Admitted on the previous night intoxicated having taken a spontaneous overdose of 30 tablets of Paracetamol. Found by a passerby in the street, she called an ambulance.

As you know we have seen James a number of times following impulsive overdoses recently. His underlying issue is clearly alcohol. He has an appointment to see WLDAS on 19th August 2013 and told me he fully intended to keep this appointment. He had no plans prior to the events of yesterday to overdose but was intoxicated in the pub, bought Paracetamol and took them on the way home. He tells me he must have been found by a passerby who called the ambulance. When I reviewed him today he told me he felt like "a dick", he had plenty to be focussing on including the birth of a baby in 4 weeks to his girlfriend. He also has plans to move through to Paisley within the next 2 weeks to be closer to his immediate family. His acceptance of his alcohol issues is changeable, it range during today's assessment from stating he realises he is placing alcohol above other responsibilities whilst in the same vein telling me that he can take or leave alcohol and he is not alcohol dependent. I therefore spent some time going through his notes with him to highlight both the physical, mental and social effects his drinking is having. He volunteered there was a counsellor in Irvine who has seen him in the past who he plans to make contact with when he moves through. There was no evidence of any mental health disorder today, I therefore discharged him with WLDAS follow-up.

Kind regards.

Yours sincerely

Dr Sarah Kennedy
Consultant Liaison Psychiatrist

20100979 8A

West Lothian Council

NHS Lothian

West Lothian
Community Health and Care Partnership

Dr ,

Dedridge Health Centre
Nigel Rise
Dedridge
LIVINGSTON
EH54 6QQ

21/08/2013

Dear Dr ,

Re – James Weir, 35 Pyothall Court, Broxburn,West Lothian
D.O.B- 12/03/1989

I am writing to advise you that I have no further appointments to meet with James. I provided him with information re NHS Addictions and encouraged him to seek help re his alcohol abuse. He had a fire in the above temp tenancy whilst being heavily intoxicated. He DNA'd his last appointment with me. I have since found out he has presented as homeless in Paisley and he has moved outwith the area. I have decided to discharge him from my caseload.
If I can be of any further assistance, please do not hesitate to contact me.
Yours sincerely

L. McLean, RMN, RGN

Lorraine McLean CPN
Homeless Health Team

Cc Dr Bett (Consultant Psychiatrist,SJH)