

Prescription Record

Name: Wesley Phillips
D.O.B: 5/12/82
Address: 80 Balfour Road
Atoley
Date: _____
Change of Add: _____
C.H.I: _____
SWIFT: _____

Drug	METHADONE			
Start Date	Dose	No. Days	Initials	Special Instructions
9/11/11	60	8		H/W
17/11/11	60	14		
1/12	60	14		
15/12	60	3x14		
9/2	60	14		
23/2	60	14		
8/3	60	14		
22/3	60	14		
5/4	60	2x14		
3/5	60	14		

Keyworker: M. Robinson **Date:** 8/11/11
Change of Keyw: _____
Prescribing Dr: _____
Change of Dr: _____
Change of Dr: _____
GP: _____
Add: _____
Phone: _____
Change of GP: _____

Drug	Quetaline 300mg 150mg			
Start Date	Dose	No. Days	Initials	Special Instructions
17/11/11	2x 300mg 150mg	14		
1/12	2x 300mg	14		
15/12	2x 300mg	3x14		
8/2/12	1x 300mg	14	U2	
9/2/12	1x 300mg	14		
23/2	1x 300mg	14		
23/2	2x 150mg	14	U2	
8/3	1	14		
22/3	1	14		
5/4	1x 150mg	2x 14		

Chemist: Boots **Date:** 8/11/11
Address: Penrice Road
Atoley
Phone No: 810 3601
Raxston
Change of Chemist: 4656
Address: _____
Phone No: _____

IN THE RUN: NO Date _____
 YES Date _____
 NO Date _____
 YES Date _____
Other instructions: _____

Prescription Record

Name: Wesley Phillips
D.O.B: 5/12/82
Address: 80 Balfour Road
Paisley
Date: _____
Change of Add: _____
C.H.I: _____
SWIFT: _____

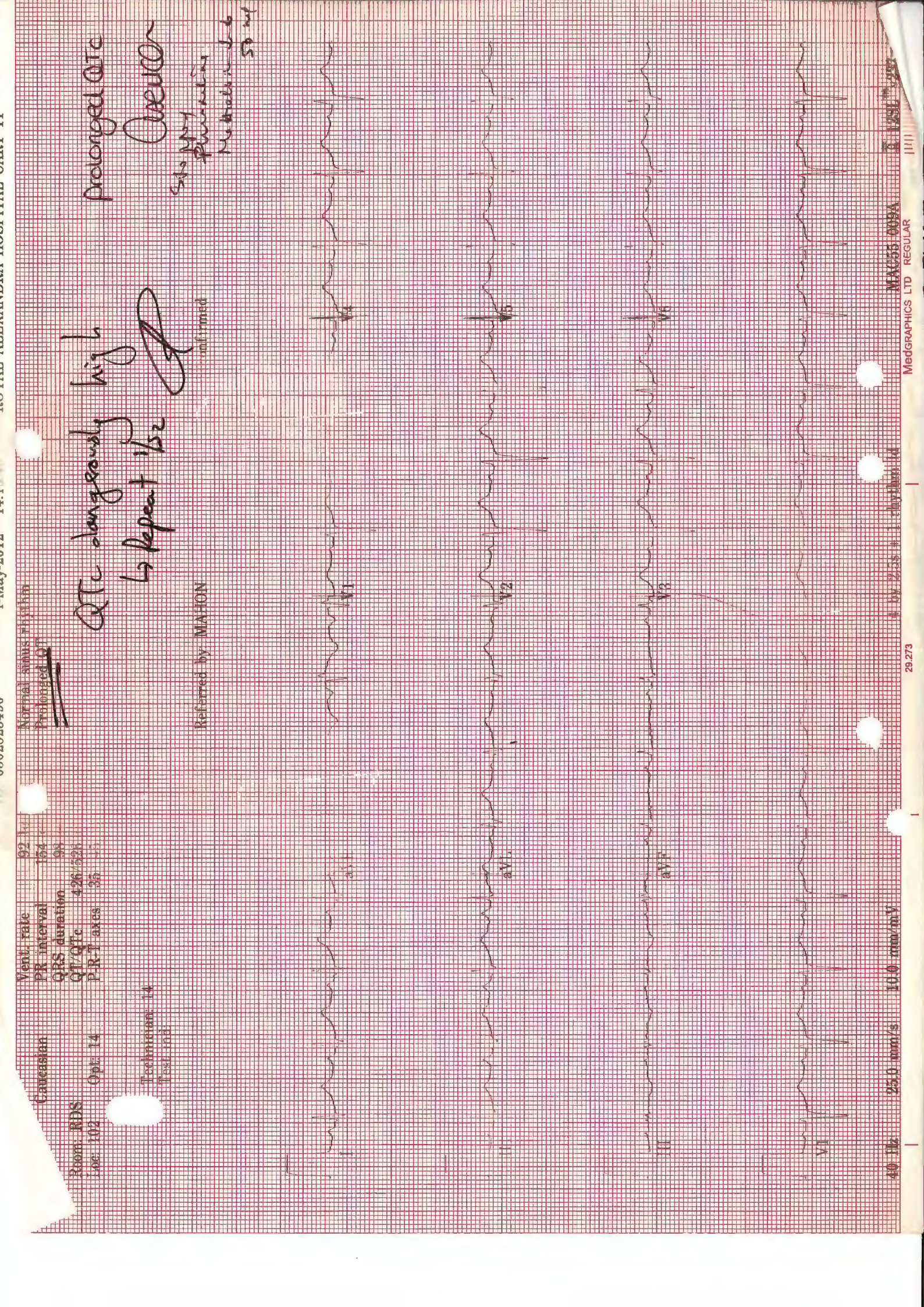
Drug	METHADONE			
Start Date	Dose	No. Days	Initials	Special Instructions
9/11/11	60	8		H/W
17/11/11	60	14		
1/12	60	14		
15/12	60	3x14		
9/2	60	14		
23/2	60	14		
8/3	60	14		
22/3	60	14		
5/4	60	2x14		
3/5	60	14		

Keyworker: M Parkinson **Date:** 8/11/11
Change of Keyw: _____
Prescribing Dr: _____
Change of Dr: _____
Change of Dr: _____
GP: _____
Add: _____
Phone: _____
Change of GP: _____

Drug	Quetalin 300mg 150mg			
Start Date	Dose	No. Days	Initials	Special Instructions
17/11/11	2x 300mg 150mg	14		
1/12	2x 300mg	14		
15/12	2x 300mg	3x14		
8/2/12	1x 300mg	14	U2	
9/2/12	1x 300mg	14		
23/2	1x 300mg	14		
23/2	2x 150mg	14	U2	
8/3	1	14		
22/3	1	14		
5/4	1x 150mg	2x 14		

Chemist: Boots **Date:** 8/11/11
Address: Penilee Road
Paisley
Phone No: 810 3601
Roxton
Change of Chemist: 4656
Address: _____
Phone No: _____

IN THE RUN: NO Date _____
 YES Date _____
 NO Date _____
 YES Date _____
Other instructions: _____



McIntosh

UNIT No.

CONSULTANT

REGULAR PRESCRIPTIONS

DRUG (Block Letters: Generic Name)

ROUTE

DOSE

Tick if

[illegible]

**PRESCRIBER'S
SIGNATURE**

PHARMA

Nov 17/19/20

Port

10

ms 60

9

DEPOT INJECTIONS

DOSE

FREQUENCY

REQUIRED PRESCRIPTIONS

DOSE

ROUTE

INDICATION

MAXIMUM FREQUENCY

ONCE ONLY

Block Letters)

DOSE	ROUTE
------	-------

TIME

SIGNATURE

GIVEN BY

Given at

TICK IF PRESCR. ON FOLLOWING SHEETS

LIST OF DRUGS T
DUE TO PREVIO

Diet

Anticoagulant

Insulin

Fluid

Chlormethiazole

15

PREScription SHEET (PSYCHIATRIC)

SHEET NO.

P20
STV0434N

Prescription Record

Name: Wesley Phillips
D.O.B: _____
Address: _____

Date: _____
Change of Add: Ø

C.H.I: 0502823456
SWIFT: _____

Drug	<u>Methadone</u>			
Start Date	Dose	No. Days	Initials	Special Instructions
<u>8/5</u>	<u>90</u>	<u>5</u>		

Date: _____

Keyworker: _____
Change of Keyw: _____

Prescribing Dr: _____
Change of Dr: _____
Change of Dr: _____
GP: _____
Add: _____
Phone: _____
Change of GP: _____

Drug				
Start Date	Dose	No. Days	Initials	Special Instructions

Date: _____

Chemist: _____
Address: _____

Phone No: _____
Change of Chemist: _____
Address: _____

Phone No: _____

IN THE RUN: NO Date _____
 YES Date _____
 NO Date _____
 YES Date _____
Other instructions: _____

39 Sunnyside Dr
Bakershead

Prescription Record

Name: West Phillips
D.O.B.: 5/12/82
Add.: 39 SUNNYSIDE BL
BALTIMORE

Change _____ Date _____
Of Add _____

C.H.I.: _____
SWIFT: _____

Date _____

Keyworker _____

Change of Keyw. _____

Prescribing Dr. _____

Change of Dr. _____

Change of Dr. _____

GP 71224212
Add. _____
Phone _____
Change _____
Of GP _____

Chemist	Date
Address	
Phone No.	
Change of	
Chemist	
Address	
Phone No.	
Change of	
Chemist	
Address	
Phone No.	

In The Run	No	Date _____
	Yes	Date _____
	No	Date _____
	Yes	Date _____
	No	Date _____
	Yes	Date _____

Other Instructions. _____

Drug	methadone			
Start Date	Dose	No Days	Initials	Special Instructions
26/3	50	14		
9/4	50	14		
23/4	50	14		
1/5	50	14		
8/5	60			
21/5	60	14		
4/6	60	14		
18/6/09	60	14		
2/7/09	60	14		
16/7	75	14		

[illegible]

Prescription Record

Name: _____
D.O.B.: _____
Add.: _____

Change Of Add _____ Date _____

C.H.I.: _____
SWIFT: _____

Keyworker _____ Date _____
Change of Keyw. _____
Prescribing Dr. _____
Change of Dr. _____
Change of Dr. _____
GP _____
Add. _____
Phone _____
Change Of GP _____

Chemist Address _____ Date _____

Phone No. _____
Change of Chemist Address _____

Phone No. _____
Change of Chemist Address _____

Phone No. _____

In The Run No _____ Date _____
Yes _____ Date _____
No _____ Date _____
Yes _____ Date _____
No _____ Date _____
Yes _____ Date _____

Other Instructions. _____

Drug	QUETIAPINE 100mg			
Start Date	Dose	No Days	Initials	Special Instructions
27/4	2	10	-	run
4/5				
21/5	200mg	14		
4/6	1	14		
18/6/09	1	14		
27/10/9	1	14		
16/7	1	14		
30/7	1	14		
13/8	1	14		
27/8	1	14		
10/9	1	14		

Drug	MIRTAZAPINE 30mg			
Start Date	Dose	No Days	Initials	Special Instructions
27/4	2	10	-	run
4/5	2	14		
21/5	1	14		
4/6	1	14		
18/6/09	1	14		
27/10/9	1	14		
16/7	1	14		
30/7	1	14		
13/8	1	14		
27/8	1	14		
10/9	1	14		

Wesley Phillips - requires urine please.

- Admitted to Leverndale via RAM 5/4/09 - stating suicidal ideation and command hallucination telling him to harm self.
- Commenced on quetiapine 100mg BD and restarted on mirtazepine 30mg
- Admitted for a period of 2 1/2 weeks - ward 4
Little objective evidence of psychosis or depression during inpatient stay although symptoms voiced by Wesley -
Most likely diagnosis made by Dr Mathias is one of harmful use of various substances, but they did note symptoms were consistent with both a psychotic illness + a depressive episode but only occurred within the context of recent drug use.
Dr Mathias stated that Wesley's drug use would not prevent a psychiatric diagnosis - can be renewed at a later date.

Contact from CMHT - Wesley did not engage with crisis team or themselves - discharged at present.

Seen by myself x 2, ^{smadisch.} last appt 5/5/09. Wesley continues to use illicit substances, discussed at length detrimental effects of illicit use on mental health + dangers of use on top of methadone script.

- Current illicit use x 20 diazepam, temazepam + x 2 bags of heroin daily / sm
- complaining of poor sleep but sleeping all day taking illicit drugs through the night.

? ↑ to 60mls methadone.

Elan.



EAST RENFREWSHIRE
COMMUNITY HEALTH AND CARE
PARTNERSHIP

file
✓



STRICTLY CONFIDENTIAL

Dr Fitzpatrick
The Lavern Medical Group
Barrhead Health Centre
201 Main Street
Barrhead
G78 1SA

East Renfrewshire CHCP
Levern Valley CMHT
7 Bank Street
Barrhead
GLASGOW
G78 2RA

Tel: 0141 577 3816
Fax: 0141 577 4049

Our Ref: CM/BL/1808520
Dictated: 27.04.2009
Typed: 29.04.2009

Dear Dr Fitzpatrick,

DISCHARGE SUMMARY

Re: **Wesley Phillips, 39 Sunnyside Place, Barrhead, G78 2RT**
DOB: **05.02.1982** CHI: **3496**

Date of Admission:	05.04.2009
Date of Discharge:	23.04.2009
Legal Status:	Informal throughout
Diagnosis:	Polysubstance Abuse
Medication on Discharge:	Methadone 50mls mane Mirtazapine 30mg nocte Quetiapine 100mg mane and nocte
Follow up:	Initially by Crisis Team, to be discussed between Substance Misuse Team and CMHT

Mr Phillips was admitted to Ward 4 of Leverndale Hospital on an emergency basis. He had presented to the RAH reporting suicidal ideation. He spoke of worsening mood over the past two weeks, and stated that he "had a rope ready" and had thought about using a nearby tree to hang himself. He also reported poor sleep, decreased appetite, partial anhedonia, and increased anxiety. Up until two weeks prior to his presentation he had reported regularly using heroin, crack cocaine, Gabapentin and Valium. He reported hearing "voices" in internal space, command hallucinations telling him to kill himself. However there was no objective evidence of him being distracted or reporting to unseen stimuli.

As you may be aware, Mr Phillips has a substantial forensic history, including spells in prison for carrying weapons and armed robbery.

Mr Phillips was admitted informally to ward 4 and initially his dose of Chlorpromazine was increased. However he developed extra pyramidal side effects when commenced on the higher dose, with significant drug induced Parkinsonism. As such the decision was made to discontinue Chlorpromazine and to commence a prescription of Quetiapine. Additionally Mr Phillips was re-established on Mirtazapine, he himself identified that his mood had been lower since this was discontinued some weeks ago.

Mr Phillips' mental state improved slowly over the coming weeks, he frequently reporting low mood and anxiety but there was little objective evidence of depression on the ward. Additionally there was little objective evidence of psychosis noted. While on the ward Mr Phillips made no attempts to harm himself and there were no outbursts of aggression.

Things slowly settled by mid April, and although there are symptoms consistent with both a psychotic illness and a depressive episode it should be noted that these have only occurred within the context of recent drug misuse and as such the most likely diagnosis is one of harmful use of various substances. However his drug use does not preclude a psychiatric diagnosis and this can be reviewed at a future date.

Mr Phillips' symptoms continued to settle and he was reviewed by myself and Dr Math on the 23rd April prior to discharge. At this point he felt that the "voices", the thoughts of self harm, and the mood were all very much improved and he was tolerating the Quetiapine well without any significant side effects. At this point it was felt that discharge home with Crisis support would be appropriate. We liaised with the local Substance Misuse Team and agreed to provide five days medication on discharge, after which point prescription would be taken over by the local Substance Misuse Team.

Follow up will be initially from the local Crisis Team and then we will discuss between the CMHT and Substance Misuse Team as to who is best placed to follow up this gentleman. If you require any further information please do not hesitate to let me know.

Yours sincerely,



Dr Chris Mathias
Staff Grade Psychiatrist

Cc: Substance Misuse Team, St Andrew's House, 113 Cross Athurly Street, Barrhead

Single Shared Assessment

Drug / Alcohol Support Needs Assessment Package

17 November 2006: Version 10

Person's Name:

Wesley Phillips

Person's DOB:

05-02-1982

Lead Assessor's Name:

Rita Gallagher

Agency of Lead Assessor:

ERC – SMT

Date of Assessment:

05-03-2009

Date of Review:

Date of Review:

Date of Review:

Completing the Drug / Alcohol Needs Assessment
WHEN COMPLETING THIS DOCUMENT PLEASE TICK APPROPRIATE BOXES AND EXPAND WHERE REQUIRED. YES – IDENTIFIES THERE ARE CONCERNS/ISSUES; NO – IDENTIFIES THAT THERE ARE NO CONCERNS/ISSUES AND N/A IS WHERE THE INFORMATION IS NOT APPLICABLE.
Section 1 – Assessment Information
Assessment Information: Client Identifier, Date of Assessment, Assessor's Name and Agency Details.
Consent Form: Check this is completed.
Section 2 – Alcohol / Drug History & Current Use
Drug and Alcohol History: Detail in chronological order starting with age when alcohol / drugs first used, which legal and illegal substances, including prescribed medication were used and what the consequences were, e.g. <i>aged 16, alcohol, intoxicated and got into a fight</i>. Also include both community and residential rehabilitation periods; this should lead up to the present day and current use. It is important to remember to put in quantities of alcohol and drug use. Should include what, how much, how taken, how often. If prescribed, IV use, where injected, sharing, use of exchange facilities. Any recent change to drug use and why. How is use funded? Any substance free periods, if so what precipitated relapse.
Section 3 – Service History Details
Detail in chronological order, starting with the first interventions sought and with which agencies, giving details of interventions provided with outcomes of the interventions. Interventions can include individual counselling, group work, substitute prescribing and detoxification. Outcomes can include reduced alcohol / drug user, change from injecting to smoking heroin, relapsed, incarcerated, achieved alcohol / drug-free status.
Section 4 – General Information / Profile
Housing: Give details of housing situation and how substance use has impacted on housing situation and vice-versa. Also include details of any periods of homelessness. Does the person move house regularly. Is the home adequately equipped and furnished. Fire Safety: Does the person meet high risk criteria for house fires i.e. lives alone, male, alcohol use, between 45-55yrs, consider referral for home safety check for fire risk. Finance: Details of income, benefits and any debts and how substance use has impacted on financial situation and vice-versa. Detail figures of income and outgoing expenses including costs of alcohol and drugs. Employment: Details of current and past employment and how substance use has impacted on employment and vice-versa. If never worked – ask if they would like to work, what would they like to do. Education: Details of current and past education experiences and how substance use has impacted on education and vice-versa. Ask about literacy and numeracy. Legal Status: Tick appropriate box. Give details of any legal situations and how substance use has impacted on legal status and vice-versa.
Section 5 – Health Information / Profile
Physical Health: Does the person smoke tobacco? Detail general health information and include history of withdrawals, seizures, hallucinations, DT's, memory blackouts, appetite, overdose, BBVs and DVTs. Psychological Health: Detail periods and history of mental health difficulties, describing any signs or symptoms that service user is reporting, e.g. low mood, anxiety, stress, sleep disturbance. Record if you have discussed hepC info and any outcomes of the discussion.
Section 6 – Social Situation/Context
Brief summary of service user lifestyle and social context, relationships – this should set the scene for moving on to childcare area. Include partner name and address and whether or not partner is a drug/alcohol user. Did user have a happy childhood, who were the significant individuals, Did they complete education. Is there current or a history of domestic violence?
Section 7 – Information on Children, Pregnancy and other Care Responsibility
Children: Tick yes or no – this should include all children that the service user is currently caring for as well as those children being cared for somewhere else.
Total Household: All those living in the one house at the address given by the service user.
Children Seen: This should be completed if children are seen with the service user at the time of assessment. Comments should include any observations made by assessor.
Other Care Responsibility: This would be any others who the service user cares for, e.g. elderly disabled, special needs, other family members etc.

Family Circumstances: Give as much detail as possible relating to family situation, e.g. relationships, children at home and living elsewhere, childcare arrangements, any concerns from service user and from assessor. If the child is not living with service user, whom are they living with? Who normally looks after the children? Are there non-drug/alcohol using adults in the family readily accessible who can provide appropriate care and support when necessary? Who would look after the children if the service user required hospitalisation or was arrested (in custody)?
Pregnancy: Provide information relating to Pregnancy Protocol and any other relevant information.
Relative / Other Agencies or Providing Child Care: Tick if child care is provided and give details of who provides this, e.g. relative – what relative, agencies – nursery, school, after school etc.
Help Required with Childcare or Arranging Childcare: Tick if this is a need – give details as to what the need is.
Social Worker: If the service user or their children have an allocated social worker, record his / her name and the office they work from, including telephone number.
Health Visitor: If the family / children have an allocated health visitor, record their name and the office they work from, including telephone number.
Children's Health Issues: This can be used to record any issues relating to children, e.g. underweight, needing dental treatment as well as any diagnosed conditions. Include behavioural/emotional problems, psychological illness or learning disability. Record any confirmation of reported information e.g. from GP/Health visitor
Progress at School / Nursery: In the parents' views are children progressing well at school or are there any difficulties – give details. Record if reported information by client is confirmed in any way e.g. contact with school or nursery
Client's Perceived Effects of their own alcohol/drug use on children: This should be children at home and those living elsewhere – does the service user think what they are doing has any effect on their children – give details. Does the parent think their child knows about their drug/alcohol use? How do they know? What is the service users perception of any difficulties? Are they willing to accept help? Have there been difficulties in maintaining contact with services in the past? What are the barriers to engaging with services?
What arrangement(s) are made for children when drug / alcohol use is being pursued / consumed: Give details
What arrangements are made for safe storage of alcohol / drugs – both legal and illegal? Give details.
Section 8 – Assessment Outcome / Plan of Care
Identified Need: List main problems identified by service user in their order of priority. This should contain details of needs identified throughout the process of assessment.
Proposed intervention: This should contain proposed intervention to meet needs identified through the process of assessment. An alcohol and/or drug misuse intervention is a policy, programme, service or project designed to bring about specified change to target areas or groups. Interventions usually involve the delivery of treatment/care to individual alcohol or drug users, often planned and implemented by several agencies working together under an integrated (shared) care arrangement. Examples of intervention are: An alcohol or drug education programme, An alcohol or drug treatment service for young people, A peer education project; A needle exchange service Describe how proposed intervention takes account of gender, ethnicity, and disability.
Timescale: This should be the date the intervention is due to start, indicating if there are any waiting times for accessing interventions.
Children's Issues and action taken: Include summary related to childcare situation and any action undertaken as a result – as worker what do you think the child needs? Is there evidence or reporting of neglect/injury/abuse now or in past? Are concerns a single incident, series of events or an accumulation of concerns over a period of time. Are there any indications that children are taking on a parenting role within families? Is there evidence of drugs/alcohol use by the child?
Summary of Assessment: This can be bullet points e.g. <i>injecting drug user with severe dependency, needs methadone maintenance treatment urgently</i>. This should also identify any further assessment required.
Unmet Need: This section should contain needs that have been identified which would be considered unable to be met at the time.
Reasons: This section should give reasons as to why these identified needs are not going to be met.
Client's Perception of the Above: This section allows for clients view of identified need and proposed interventions, as well as any other aspects of assessment.
No further action /referral to other agency: Detail why no further action required. If referral on initiated identify whom to and why. If referral required for home safety fire risk identify here.
Assessor's Signature: Sign and printed in block capitals by Assessor. With date completed.
Client's Signature: Signed and printed in block capitals by Service User. With date completed.
RISK ASSESSMENT: It is the responsibility of each participating organisation to ensure that individual Risk Assessments are completed on each service user as agreed within the organisation's protocols.

Section 1: BASIC INFORMATION			
Person's Full Name:	Wesley Phillips	CHI / PIMS Number:	3496
Address	48 Braeside Drive Barrhead	SWIFT/CARE FIRST Ref No:	P12291
GP (name, address and telephone number)	Dr Fitzpatrick Levern Valley Practice Barrhead Health Centre	Date Consent Form Completed:	05-03-09
Location (where seen):	St Andrews House	Date of Birth:	05-02-82
Section 2: ALCOHOL / DRUG CURRENT USE & HISTORY			
Drugs / Alcohol History: Please indicate onset / development of difficulties, short history leading to present use (present use should be more detailed). Indicate type of substance (legal (L), illegal (I) or prescribed (P). Method of Use			
Current			
Substance Used (What, how much, how often, and last used)	Type (L, I or P)		
Last smoked heroin 2 nd March £20 Diazepam 30-100 x 10mgs daily DF118 taken when available Cocaine last week shared and smoked 2grms with friend Methadone Sunday 40mls taken when available Subutex when available Two pints of lager last week	I I I I I I	Overall drug use erratic and chaotic.	
Have you ever injected?	YES	X	NO
Have you ever shared injecting equipment?	YES	X	NO
Comments – relating to above Reports last IV July 2007. Hep C positive Aug 2008.			

History Please indicate onset / development of difficulties, short history leading to present use (present use should be more detailed). Indicate type of substance (legal (L), illegal (I) or prescribed (P). Method of Use

Age	Substance Used (What, How much, How Often)	Type (Legal, illegal or prescribed)	Consequences
8/9 years	Gas, glue for approx 1- 2 years	L	Problematic behaviours
9 years	Cannabis, alcohol	I/L	Problematic behaviours
12 years	Occasional ecstasy and amphetamine use	I	Problematic behaviours at school and at home.
14 years	First smoked heroin sates uncle was a dealer in Greenock. First tried methadone. Heavy drinking	I	Problematic behaviours
16 years	Heroin dependent very quickly moved to IV use. States after a few months ceased daily use of heroin moving to occasional heroin use as part of chaotic list of poly drug use: Heroin, alcohol, benzodiazepines, methadone and DF 118.	I	Offending
25/26 years	Commenced methadone Inverclyde CDT June 06 – July 07. Continued with poly drug use up until present day. Interrupted only by periods of custody.	L/I	Offending

Section 3: SERVICE HISTORY DETAILS						Yes	No	N/A	
Current and Previously Known Details: Please indicate whether client has any other current involvement, and whether s/he is previously known to this agency and / or other agencies									
Contact Details, Named Worker (address & telephone), Dates of Involvement		Interventions			Outcomes (Please include dates)				
CDT Inverclyde 2007		Methadone prescribing			Brief contact – disengaged with treatment due to custodial sentence.				
Christian 2006 Rehab England		Residential rehabilitation			Put out after one week due to inappropriate behaviour towards other female resident and aggression towards others.				
Christian Rehab 27 th Feb 2009- 03-11 Birmingham		Presented at rehab gave information but not admitted as he was intoxicated. Asked to return on Monday where he was refused admission due to offending history.							
Section 4: GENERAL INFORMATION / PROFILE									
HOUSING (tenancy, problems, complaints, arrears, length of tenure)						Yes	No	N/A	
Details: Following a period in Overlee 2007 having moved to ERC from Port Glasgow. Mr Phillips moved temporarily into a temp homeless flat before being offered a LA flat 2007. [REDACTED] (ERC Housing) has advised that during her contact with Mr Phillips he appeared to be drug free and coped well living independently requiring the very minimum of support in maintaining independent living									
FIRE RISK: Information given	YES	NO	Leaflet Given	YES	NO	Referral On	YES	NO	DECLINED
FINANCE (present income, outgoings and debts)						Yes	No	N/A	
Details: Income Maximisation Required?						Yes	No	N/A	

EMPLOYMENT (Past/current difficulties, literacy and numeracy)	Yes	<u>No</u>	N/A
Details: Advises of no employment history.			
EDUCATION (Past/current difficulties, literacy and numeracy)	Yes	No	N/A
Details: Reports none			
CURRENT LEGAL STATUS (Please indicate status below)	Probation	In prison	<u>N/A</u>
Details:	Licence	DTTO	
	Other	DTTO Assessment	
Current / outstanding offences:	Yes	<u>No</u>	N/A
Previous offences:	<u>Yes</u>	No	N/A
Mr Phillips reported that aged: 16 years – Greenock prison for threatening parents with pick axe 18 months probation. 16 years – Breach of Peace – parent house 4 weeks sentence. 19 years – CS gased by police in parents house alcohol/ intoxicated. 24 years – served 30 days carrying a knife – telephoned police to advise he felt like murdering himself or someone. 25 years – Robbed a shop with knife July 07 – 2 Sept 2008.			
Any other details (including any periods in prison)			
As above. Mr Phillips reports to have attempted to rob a woman when in England 4 th September 2008 with a knife he did not say if the police were involved.			

Section 5: HEALTH INFORMATION / PROFILE

Physical Health

(including hospital admissions, current prescribed medication, Hepatitis B vaccination, Hepatitis C information, pregnancy)

Smoker – If yes, how many?

States he ceased smoking Sept 2008

Y

N

Hep C diagnosis 2008.

Psychological Health

(including hospital admissions and current prescribed medication)

Reports the beginning of self injury aged 16 years. Ceased this in 2007 when he cut his throat. Significant scarring evident to both arms and throat (Mr Phillips mother died while he was in custody).

Advises o brief periods in psychiatric hospital:

Inverclyde aged 16 years

Stobhill 2005

RAH 2006

Mr Phillips reports no current medication although referral from Dr Fitzpatrick details all current medications (please refer to this).

Section 6: SOCIAL SITUATION / CONTEXT

Living / domestic arrangements; family relationships (past and present); current / history of domestic violence

Current

Following the death of his mother in January 2007 and release from custody shortly after Mr Phillip moved to the Barrhead area where his father resides. He was placed in Overlee House, eventually accessing his own LA tenancy where he currently resides. Since his release he reports uncontrollable chaotic drug use and unpredictable aggressive behaviour. He advises that he is currently in the process of attempting to access a Christian Rehab in Wales. Reports and presentation suggest that Mr Phillips has severe mental health problems and also forensic history. Other than his father he does not appear to have any significant supports in the area. However Mr Phillips states he makes use of supports through the Teen challenge organisation.

Past

Mr Phillips was born in Port Glasgow he is the youngest of two other siblings (2 brothers living in Port Glasgow/ Wales). His parents separated when he was 19 years. Mr Phillips describes introduction to substance use from a very young age and advises that close family members were involved in drug dealing. Early childhood through to his late teens he advises of police involvement due to assaults to his parents. Information gathered suggests previous diagnosis of ADHD in childhood and a tourettes diagnosis in his teens. Mr Phillips advised of psychiatric treatment due to self injury from age 16 years to 25 years although his account of this is unclear.

Section 7: INFORMATION ON CHILDREN, PREGNANCY & OTHER CARE RESPONSIBILITIES

Children?	Yes	<u>No</u>	Contact with children?	Yes	No					
Name	D.O.B	Address	Main Carer	Nursery /School	SW Status					
Who is in the household?		Number of Adults		Number of Children						
					Under 16					
					Over 16					
Children seen?	Yes		No							
Comments (Clarify if this information has been verified)										
Pregnancy										
Is client pregnant?	Yes	No	Is partner pregnant?	Yes	No					
If yes, stage of pregnancy:										
Are they drug/alcohol users:			Yes	No						
Are they attending ante-natal care			Yes	No						
Are maternity services aware of drug/alcohol use:			Yes	No						
Comments:										
Other care responsibility?			Yes	No	N/A					
Name	DOB	Address			Main Carer					

Relatives / other agencies arranging childcare:	Yes		No		N/A	
Help required with children or arranging childcare:	Yes		No		N/A	
Social Worker:	Yes		No		N/A	
Health Visitor:	Yes		No		N/A	
Children's health issues:	Yes		No		N/A	
Progress at school / nursery	Yes		No		N/A	
Client's perceived effects of their own or others alcohol / drug use on children	Yes		No		N/A	
What arrangements are made for children when drug / alcohol use is being pursued / consumed?	Yes		No		N/A	
What arrangements are made for safe storage of alcohol / drugs (both illegal and prescribed)?	Yes		No		N/A	

Section 8: ASSESSMENT OUTCOME / INITIAL PLAN OF CARE

Identified Need (Should be in order of priority of user)	Proposed Interventions (Demonstrate how intervention will take account of gender, ethnicity and disability)	Timescale (Include person responsible)
Mr Phillips was not clear around what he wanted from this service. Stating "I need something to get Me by until I go into rehab". He was clear that he did not want methadone prescribing.	Appointment to be seen by Dr McMahon on 12-03-09 for assessment of treatment needs.	12-03-09

Please identify any factors related to children's issues arising from assessment and action taken:

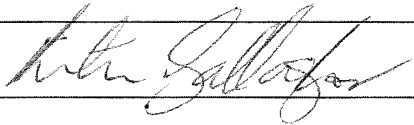
Summary of Assessment

Mr Phillips has a long history of problematic poly drug use which may or may not be the cause of psychiatric symptoms in the past and current presentation. A report from ERC housing stated that in his period of residing in temporary accommodation he appeared stable, of good presentation and coped with daily living with little support. The same member of housing staff who worked closely with Mr Phillips met him on the 9th March and advised me that he was almost unrecognisable and difficult to understand. As a result of his complexities and for further psychiatric assessment Mr Phillips will be offered an appointment with Dr McMahon. One available urine screen (dipped) 05.03.09 positive for benzo's and buprenorphine.

Unmet Need	N/A	Reasons

Client's Perception of the Above

No further action / Referral to other agency (please give details why)

Service Users Signature: 	Date 05-03-09
Assessors Signature:	Date

1.ipped 05-05 2007
05. bened's subtex.

Two extremely faint lines
methadone, morphine.

RECORD OF ADMISSIONS AND OUT-PATIENT/DAY ATTENDANCES

[illegible]

Argyll & Clyde Health Board

Greater Renfrewshire Division Adult Mental Health

REFERRAL ASSESSMENT

Date Assessed	27/06/06	Time of Assessment (24 Hour)	0100
Surname	Philips	G.P. Name	Much
Forename & Initial	Wesley	G.P. Address (No. & Street)	Port Glasgow surgery
Date of Birth	05/02/82	Town	
Address (No. & Street)	45 Prospect hill Gt	'Phone No.	
Town	Greenock	Employment Status	
Post Code	PA15 6ER	Referred By:	A+E
'Phone No		Interviewers Names	1. A. GIBB 2. C. RICHFORD
Social Contact	Christine Philips	Admitted Hosp. & Ward	
		Not Admitted	✓

History of Presenting Illness

A+E. Well known to Greenock psych services. Their policy is not to admit. Today had chest pain on train to Paisley.

HPC

- Was "caught" shop lifting 3 days this week
- "I phoned church member to tell him about it"
- "I felt guilty, he told me I was going to die and was going to hell"
- Since then this has been on his mind.
- State he has been feeling suicidal since.
- Having thoughts that he is going to die or be murdered.
- Thoughts are telling him to harm himself.
- Last week was "alright" Mood OK

- before shoplifting
- Mood OK
 - Sleeping well "because I was taking valium & heroin"
 - Appetite OK
 - Optimistic about future
 - Poor energy "due to valium"
 - Usually just sits about the house
 - No thoughts of self harm / suicide

- Recently started on methadone 40mg / day (last Thurs)
- No recent self harm.
- No suicidal intent
- No psychotic features or delusions (PTO)

- Patient admits to feeling optimistic about the future because he has been seeking help from the church
- He is on an 8 week assessment by them to evaluate whether or not he can attend a rehabilitation programme
- Patient asked me if I believed this could help him
- Patient admitted to having a diagnosis of personality disorder and appear to be quite knowledgeable about the subject.
- After ~~lengthy~~ lengthy discussing with patient, about personality disorder, drug abuse ect, he appeared more settled and described feeling optimistic.

I explain that after recent upset can have evoked intense emotions and that after personality disordered patient find it difficult to see past

I feel that patient has been helped simply by talking through his concerns

Modified Sainsbury's Risk Assessment Done:-

Past Psychiatric History

Personality ~~Disorder~~ Disorder
Diagnosed Tourette's aged 15 years

- Multiple self harming
cutting, O.Ds,

Past Medical History

nit of male

Current & Past Medication

Name	Dose	Frequency	Current/Not Current	Other Information
Percocet		(not taking at present)		
Lidocaine		(not taking at present)		
Methadone	40mg	Daily		
			* NSAIDS *	

Family History

Mother	Lives with Mother. She is currently [REDACTED] Feels he gets on well with mother but "puts her through it"
Father	Father lives in Banhead. Not a good relationship
Siblings	2 older brothers.
Children	No children

Personal History

Birth/Childhood	
School/Education	

(Primary/Secondary Qualifications)	
Occupations	Previous documented
Relationships	
Family Psychiatric History	
Pre-morbid Personality	
Social Circumstances	
Finances	DLA income support. Some debt.
	No debt collector.
Housing	Lives with mother. OK condition.
Childcare	N/A
Employment	N/A
Smoking	10 cpd.
DRIVING	not driving

Illicit Drug usage & Alcohol History

Recent Heroin, valium & cannabis
abuse.

No benzos or cannabis lately
on Methadone.

C.A.G.E. Questionnaire

Units of Alcohol per week

no alcohol at present

Forensic History

- 60 day prison sentence at start of 2006
possession of offensive weapon
- Has been remanded at times, Threatening behaviours
- Breach of the peace.

Effect of Presenting Problem on Daily Living**Effect of Presenting Problem on Relationships with Others**

Mental State Examination	
Appearance & Behaviour	Unshaven but otherwise well kept. Good eye contact and good rapport. No agitation or retardation evident.
Affect: Objective & Subjective	S - down O - euthymic - reactive affect
Speech	Spontaneous, mild speech impediment Normal rate & tone
Thought	No FTD
Form	Preoccupation with discussion he had with church elder
Content	No delusions, obsessions
Perceptual Abnormalities	Nil
Cognitive Function	Orientated in time, person & place
Intelligence	
Insight	Retained

Summary

24 year old man with history of personality disorder characterised by impulsivity, often aggressive behaviour and self harm. Presented after days of suicide ideation following upsetting conversation with friend at church

Collaborative Information

nil

Differential Diagnosis

① Personality disorder

No evidence of depression or psychosis

Focus of Patient Care

- ① Advised to continue his approach to ~~stabilisation~~ *getting better* i.e. methadone, religious route, GP care.
 ② Given advice on how to access help lines
 ③ Taxi home

Discussed with:-

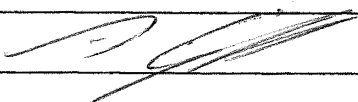
Admitted To Ward:-

Not Admitted ✓

Time finished! - 2 am

Signatures of Assessors

1



2

Mental Health & Learning Disabilities

Source: Sainsbury Centre for Mental Health

RISK ASSESSMENT AND MANAGEMENT (LEVEL 1)

CLIENT NAME: Wesley Phillips D.O.B.: 05 / 02 / 82 ID No:

ADDRESS: 45 Prospect Hill Court, Glenageary POSTCODE:

DATE/PERIOD OF ASSESSMENT: 24 / 6 / 16 TIME: 01:00 REVIEW DATE: 1 / 1

RISK FROM OTHERS (eg. Abuse, exploitation)

YES / NO

UNKNOWN

Details of identified risk:

Further investigation required*

RISK TO SELF (eg. Suicide, self harm)

YES / NO

UNKNOWN

Details of identified risk:

DESCRIBES PREVIOUS EPISODES OF CUTTING SELF, TAKING OVERDOSES & HANGING SELF. ONCE STATES HAS THOUGHTS OF KILLING SELF. NO PLAN STATED.

Further investigation required*

RISK TO OTHERS (eg. Aggression, violence)

YES / NO

UNKNOWN

Details of identified risk:

EXTENSIVE FORENSIC HISTORY, CHARGED WITH ASSAULT FREQUENTLY. STATES HAS ANGER MANAGEMENT PROBLEMS AND DOES NOT LIKE AUTHORITY FIGURES. PREVIOUS SPASMS UP INVERCLYDE DAY HOSPITAL.

Further investigation required*

RISK OF NEGLECT (eg. Health, personal)

YES / NO

UNKNOWN

Details of identified risk:

Further investigation required*

RISK TO CHILD(REN) (eg. Neglect, abuse)

YES / NO

UNKNOWN

Details of identified risk:

Further investigation required*

RISK OF PHYSICAL IMPAIRMENT (eg. Medical, sensory)

YES / NO

UNKNOWN

Details of identified risk:

Further investigation required*

RISK OF WANDERING and/or FALLS

YES / NO

UNKNOWN

Details of identified risk:

Further investigation required*

MEMORY & COGNITIVE IMPAIRMENT

YES / NO

UNKNOWN

(eg. Forgetfulness)

Details of identified risk:

Further investigation required*

CHALLENGES TO SERVICES

YES / NO

UNKNOWN

(eg. Inappropriate demands, poor service response)

Details of identified risk:

Presents to this Health area, Inverclyde. Refuse to see Wesley out of Hours.

Further investigation required*

* Any further investigation required should be part of level 1 Risk Management Plan.

SIGNIFICANT KNOWN HISTORY (including known diagnoses):

STATES DIAGNOSED TOURETTE SYNDROME APR 15
PREVIOUS CARE AT TINKERLYDE. STATES TINKERLYDE HAVE
WITHDRAWN FROM HIM & HAS NO CONTACT.
STATES HAS BEEN DIAGNOSED AS PERSONALITY DISORDER. HAS
ABUSED DRUGS, CURRENTLY ON METHADONE.

INITIAL ASSESSMENT OF RISK (including context, situations in which risks may occur):

STATES LONGSTANDING SUICIDAL THOUGHTS, NO
PLAN. NO INTENT STATED.

INITIAL RISK MANAGEMENT PLAN (including who is to do what):

NOT FOR ADMISSION
ADVISED TO SEE OWN GP
CONTRACT TAXI
SAMARITANS NUMBER PROVIDED.

SOURCES OF INFORMATION AVAILABLE

Wesley, Previous Assessment 29/01/06, Duty Nurse
Tinkerlyde.

CONTEXT OF CLIENT FOR ASSESSMENT

ROLE OF CLIENT and/or CARER IN PLAN:

CLIENT INVOLVED: YES / NO

CARER INVOLVED: YES / NO

CLIENT AGREED: YES / NO

CARER AGREED: YES / NO

COMMENTS:

NEED FOR RISK ASSESSMENT & MANAGEMENT (LEVEL 2) YES / NO

Recorded by: *Antony Ruffin* Date: *24/6/16*

Discussed with: *Mark Gibb* Time: *01:30*

DRUG PRESCRIPTIONS IN A&E (INCLUDING TETANUS PROPHYLAXIS)

Date Given	Drug (block capitals)	Dose	Method of Administration	Time of Administration	Signature	Given by

Consultant..... *DP*

Seen By..... *Lawson* Time..... *23:40*

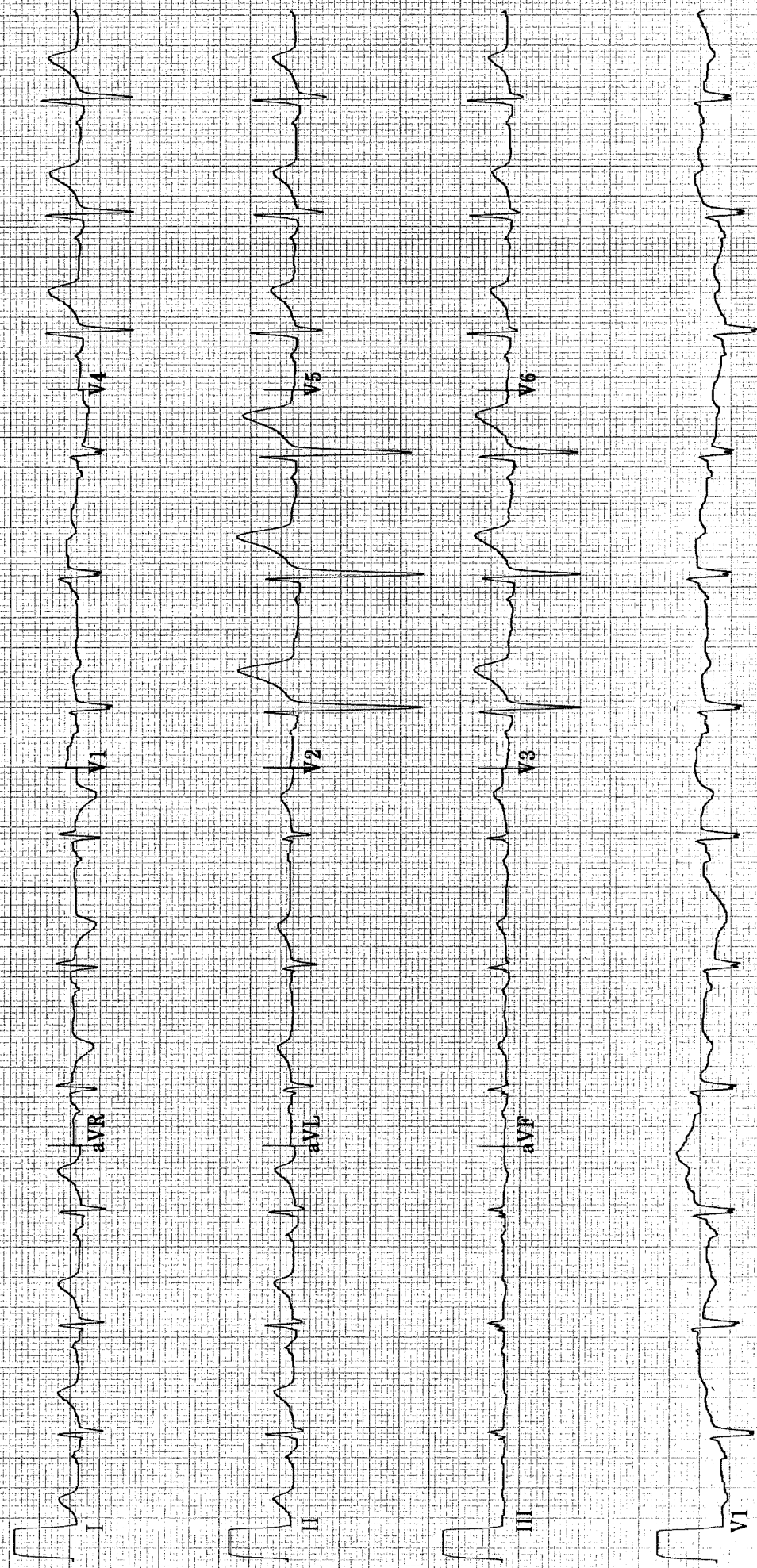
Date	<i>23/6/86</i>
	<i>24 ♂</i>
	<i>cls ~ 3 have history lower central slap dent pain at vert in tooth - tight - vomited spontaneously felt in pain + SOB c pain has vomited 3 times today</i>
	<i>also cls ↑ thoughts of mortality today hears "thoughts" in his head (not his own voice) telling him he's watching going to die, he should end his life - no specific plan currently but feels he may act? on this</i>
	<i>AMH: personality disorder substance abuse ? psychotic dependent</i>
	<i>MI: methadone trial non-compliant c & med</i>
	<i>CH: lives c parents in Greenock</i>

5-Feb-1982
Male Caucasian
Room: Loc. 0 Opt:
Vent. rate 75 bpm
PR interval 160 ms
QRS duration 94 ms
QT/QTc 412/450 ms
P-R-T axes 38 93 29

Technician:
Test ind:

Referred by:

Unconfirmed



Body Part Stamp

AE Compulsive
of A/Ly U or

pulse 72
BP 177/89
HR 1 + 1 + 0

Sex 9PM aa
O/A Chest clear
equal AE

chds SNT

ECG: SR, nil acute

Fairly well kept
Good eye contact / rapport
No overt psychosis.

Date

Drug: anxiety / psychotic depression

W/ W ψ M.

→ will r/v at acute
assessment unit by the way.

A

DISCHARGE DRUG PRESCRIPTIONS

Date Given	Drug (block capitals)	Dose	Method of Administration	Time of Administration	Signature	Given by

Discharge Codes (please circle)

1. Discharge Home	2. Refer GP	3. A&E Clinic	4. Fracture Clinic
5. Other Clinic	6. Transfer	7. Admit Ward	8. Patient Deceased

Argyll & Clyde Health Board

Greater Renfrewshire Division Adult Mental Health

REFERRAL ASSESSMENT

Date Assessed	1 8 1 0 0 5	Time of Assessment (24hr)	0 2 3 0
Surname	PHILLIPS	G.P. Name	Dr Mutch
Forename & Initial	WESLEY	G.P. Address (No. & Street)	Dubbs Road
Date of Birth	0 5 0 2 0 2	Town	Port Glasgow
Address (No. & Street)	45 Prospect Hill Court	'Phone No.	
Town	Greenock	Employment Status	unemployed
Post Code	P A 1 S 4 E E	Referred By:	GP (REMS)
'Phone No		Interviewers Names	1. Margie Fennell 2. Paul Phillips
Social Contact		Admitted Hosp. & Ward	
		Not Admitted	☒

History of Presenting Illness

16/08/2005 current location [redacted]
 48 Fairside Drive Bear Glasgow
 G78 2AB

Present known to the service in Inverclyde.
 Has a diagnosis of tunnel vision. Normally lives with his mother in Greenock [redacted].
 [redacted] involved since mother's complaint of early dementia and an urge to self harm.
 Since mother's hospitalization living with his father at the above address.
 Feels suicidal tonight. Accompanied to hospital by the father.
 Thoughts of cutting himself. No active plans.
 No recent DSH. Last admitted to IRR following an OD 3 years ago.
 No mood swings 3-4/10. No diurnal variation.
 No paranoid ideation.
 No sleep disturbances - intermittent waky up. Feels anxious particularly at night. Thinks "I am going to have a heart attack".

Appetite U stable

No problems C concentration & memory.

Feels paranoid about going out. unable to elaborate

No auditory / visual hallucinations.

Hx from the father.

Behavioural problem since the age of 7. Diagnosed Tourette at 15 by a specialist in Birmingham.

Has attended Low field child & family centre until the age of 16.

Therapist contact of adult mental health service in Inverclyde.

Short admission to the short stay psychiatric unit at IRH (2 weeks).

Unit at IRH.

Father is very let down by the mental health services & has "system" "Nobody wants to help" "Investigated for Huntington's" at IRH

Given a low obsessional compulsive symptom i.e. taking & showering a day.

on Paroxetine & carbamazepine - not been taking regularly

Problem of mood fluctuations & self-harm behaviour on permissibility. No current tic associated C Tourette's. patient & family unhappy of the services.

Modified Sainsbury's Risk Assessment Done:-

Past Psychiatric History

As above.

Tourette's.

contact C child & family & adult mental health service in Inverclyde

contacted IRH - ward A-East. one previous admission (2 weeks). No other information available

Past Medical History

Tourette's - diagnosed at my age of 15

Current & Past Medication

Name	Dose	Frequency	Current/Not Current	Other Information
PAROXETINE	30 mg	Od	current	not taking
CARBAMAZEPINE	200 mg	Bd	current	too much for 1 month

Family History

Mother	currently in hospital - IRH & an MI 56 years
Father	50 years - parents separated
Siblings	2 older brothers - living independently
Children	Nil

Personal History

Birth/Childhood	Born in Germany. Moved to port of Spain at 2
School/Education	Attended school in port of Spain. Frequently suspended for bad behaviour

(Primary/Secondary Qualifications)	Expelled at 18 - was in a home for 8 months
Occupations	Has done a number of temporary jobs. Last one - 2 years ago
Relationships	only short term relationships.
Family Psychiatric History	
Nil	
Cousin - ADHD	
Pre-morbid Personality	
Emotional & behavioural problem since childhood.	
Social Circumstances	
Finances	On benefits
Housing	Lives with mother
Childcare	N/A
Employment	unemployed.
Smoking	~ 10/day

Illicit Drug usage & Alcohol History

Don't any current abuse of alcohol.

past. Has taken heroin, speed ecstasy in the
last year 18 months ago.

C.A.G.E. Questionnaire

Units of Alcohol per week

Forensic History

Has been arrested a number of times
for police assault, breach of peace.
3 weeks in Remand

No incidents in the last 1 year.
Nothing pending.

Effect of Presenting Problem on Daily Living

do social withdrawal

Effect of Presenting Problem on Relationships with Others

Difficult relationship w/ parents

Mental State Examination	
Appearance & Behaviour	casually dressed in jeans + T shirt. Reasonably compt. Maintained good eye contact. Reasonably good rapport during the interview. Fairly calm & relaxed.
Affect: Objective & Subjective	- low.
	Affect is reactive. Mood appears appropriate to the context.
Speech	Normal in rate, tone & rhythm logical & coherent.
Thought	Thought of self harm. No definite plan
Form	- NFD
Content	Vague paranoid thought. Not in delusional intensity
Perceptual Abnormalities	- no perceptual disturbances
Cognitive Function	- oriented in time, place & person Attention, concentration & memory intact
Intelligence	
Insight	Poor insight into the nature of her illness. unrealistic expectations

Summary

23 yr ♂ Δ-Tourette's syndrome. Long standing hb
emotional & behavioural disturbance w/o any
evidence of major mental disorder.
Low threshold for disturbance in emotion &
behaviour. Recent life events likely to have caused
disturb & current behaviour
Poor compliance w medication

Collaborative Information - Father.

Differential Diagnosis - Tourette's Disorder.

Focus of Patient Care

Advised to register w a party up for
a referral to the Rethinking mental health
service.

No indication for an emergency admn.
i.e. no evidence of major mental disorder.
Difficulties are long standing.

Client & family not satisfied w the actual
client became disruptive but settled
quickly.

Discussed with:-

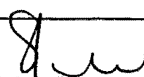
Short course of chlorpromazine so my glass

Admitted To Ward:-

Not Admitted ✓

Signatures of Assessors

1


(M. Farnand-SH2)

2



Mental Health & Learning Disabilities

Source: Sainsbury Centre for Mental Health

RISK ASSESSMENT AND MANAGEMENT (LEVEL 1)

CLIENT NAME: Wesley Phillips D.O.B.: 1 / 1 ID No: PAIS 4ER
ADDRESS: 45 Prospect Hill Court, Greenock POSTCODE: PA15 4ER

DATE/PERIOD OF ASSESSMENT: 18/10/05 TIME: 2:30 REVIEW DATE: 1 / 1

RISK FROM OTHERS (eg. Abuse, exploitation)

YES / NO UNKNOWN

Details of identified risk:

Further investigation required*

RISK TO SELF (eg. Suicide, self harm)

YES / NO UNKNOWN

Details of identified risk:

H/o deliberate self harm by self laceration. ongoing mkt.

Further investigation required*

RISK TO OTHERS (eg. Aggression, violence)

YES / NO UNKNOWN

Details of identified risk:

H/o assault & breach of peace

Further investigation required*

RISK OF NEGLECT (eg. Health, personal)

YES / NO UNKNOWN

Details of identified risk:

Further investigation required*

RISK TO CHILD(REN) (eg. Neglect, abuse)

YES / NO UNKNOWN

Details of identified risk:

Further investigation required*

RISK OF PHYSICAL IMPAIRMENT (eg. Medical, sensory)

YES / NO UNKNOWN

Details of identified risk:

Tourette's disorder

Further investigation required*

RISK OF WANDERING and/or FALLS

YES / NO UNKNOWN

Details of identified risk:

Further investigation required*

MEMORY & COGNITIVE IMPAIRMENT

YES / NO UNKNOWN

(eg. Forgetfulness)

Details of identified risk:

Further investigation required*

CHALLENGES TO SERVICES

YES / NO UNKNOWN

(eg. Inappropriate demands, poor service response)

Details of identified risk:

poor compliance & medication

chronicity of the illness re Tourette's.

Further investigation required*

* Any further investigation required should be part of level 1 Risk Management Plan.

SIGNIFICANT KNOWN HISTORY (including known diagnoses):

23 yr ♂ known Tourette's disorder. Long
standing hb emotional & behavioural
difficulties. Long hb deliberate self harm
poor compliance & medication.

INITIAL ASSESSMENT OF RISK (including context, situations in which risks may

occur):

Intermittent risk of deliberate
self harm. Low threshold for emotional
& behavioural disturbances.
Self harm behaviour worsened by personal/social
stressors.

INITIAL RISK MANAGEMENT PLAN (including who is to do what):

pt currently residing @ an Inclusive AP.
Advised by GP & party of it that it
residing in this area.
Any immediate intervention is unlikely
to avert the existing risk.

SOURCES OF INFORMATION: AVAILABLE

Client
Family of the client

CONTEXT OF CLIENT FOR ASSESSMENT

ROLE OF CLIENT and/or CARER IN PLAN:

CLIENT INVOLVED: YES / NO

CARER INVOLVED: YES / NO

CLIENT AGREED: YES / NO

CARER AGREED: YES / NO

COMMENTS:

Client & family not satisfied @ the advised
outcome. Demanding immediate intervention
unrealistic expectation.

NEED FOR RISK ASSESSMENT & MANAGEMENT (LEVEL 2) YES / NO

Recorded by:

Marque Fernando

Date:

18.10.08

Discussed with:

Paul Phillip

Time:

2:30 am

Call No.: 95171		NHS ARGYLL AND CLYDE		Date: 17-Oct-2005 22:55	
Call Category: PCC			Priority: Within 1 Hour		
Age: 05-Feb-1982 (Age: 23 years)			Patients Name: Wesley Phillips		
Current Location: 48 Braeside Drive Barrhead Glasgow			Home Address: 45 Prospecthill Court Greenock		
G78 2QB			PA15 4ER		
Tel. No.: 0141 580 0223			Tel.No.: 01475 800482		
Caller Origin: Other		Caller Name: Alex		Tel. No.: 0141 580 0223	
Gender: Male		Community Health Index: 0502823496			
Temporary Resident:		Surgery: Medical Centre (Drs Mutch)		GP: Mutch, M	
Reported Condition: SUICIDAL SEE A/V					

NHS24 Ref.No.: 2491304		NHS24 Date/Time: 17-Oct-2005 22:40	
NHS24 Consultation Start: 17-Oct-2005 22:46		NHS24 Consultation Complete: 17-Oct-2005 22:50	
NHS24 Outcome: Dr to phone patient within 1 Hr			
NHS24 Clinical Summary: Clinical summary created: 17-Oct-2005 MENTAL HEALTH HISTORY, SELF HARM, EXTENSIVE SOCIAL WORK HISTORY AS CHILD, SUICIDAL TONIGHT, MOTHER UNWELL ++, DAD REQUESTING INPUT ASAP RE REFERRAL TO SERVICES, NOT KNOWN TO PSYCHIATRY IN AREA, PREVIOUSLY MANAGED IN ENGLAND, DISCUSSED IN HOURS ROUTE OF REFERRAL, DEMANDING HELP TONIGHT, DR TO CALL PLEASE.			
Past Medical History: MENTAL ILLNESS			
Medications: ROXOTINE CARBAMAZAPINE			
Allergies: NIL KNOWN			
TIMES:- Arrival time: 23:46 Cons. begin: 23:46 Cons. ended :			
Consulting Doctor: [Print Name] Murray, W		[Signature]	
Clinical Notes: (Use reverse of form for examination report) LONG STORY OF SELF HARM AND FATHER FEELS HE WILL SELF HARM TONIGHT AND NEEDS ADMITTED. SUGGEST HE BE ASSESSED AT PCC LONG STORY OF SELF HARM AND FATHER FEELS HE WILL SELF HARM TONIGHT AND NEEDS ADMITTED. SUGGEST HE BE ASSESSED AT PCC MOROSE AND INSISTENT HE IS SUICIDAL. LONG HISTORY OF TROUBLED ADOLESCENCE/TOURETTE`S. HAS OCDISORDER. FEELS DEPRESSED AND VERY ANXIOUS RE HIS HEART AND IS GETTING COMPULSIONS TO SELF HARM.			
Prescribed Medication:			
Follow-Ups:			

ADMISSION RECORD PSYCHIATRY

Copies: white - Nursing
yellow - Medical Records
green - Medical Records Dept.
pink - Social Work Dept.

HOSPITAL *RAH* Ward *3*
CONSULTANT *DR ANDERSON* Day *THURSDAY*
HOSPITAL NUMBER *0502823496*
DATE OF CURRENT ADMISSION Day *29* Month *01* Year *00*

P A T I E N T	Surname (Block Letters) <i>PHILLIPS</i> Mr / Mrs / Miss <i>(3496)</i>		TIME OF ADMISSION <i>04 50AM</i>	A D M I S S I O N
	FORENAMES <i>NESLEY</i>		TYPE OF ADMISSION <i>EMERGENCY</i>	
	MAIDEN SURNAME		STATUS ON ADMISSION <i>INFORMAL</i>	
	SEX <i>MALE</i> AGE <i>23YR</i> DATE OF BIRTH Day <i>5</i> Month <i>02</i> Year <i>82</i>		REFERRED TO HOSPITAL BY <i>SELF</i>	
G P	PRESENT MARITAL STATE: Never Married / Married / Widowed / Divorced / Separated / Not Known		MODE OF TRANSPORT	G P
	HOME ADDRESS <i>43 PROSPECTHILL COURT GREENOCK</i>		RESIDENCE IMMEDIATELY PRIOR TO ADMISSION <i>HOME</i>	
	OCCUPATION () <i>LINEMAN</i> ()		PREVIOUS HOSPITAL CARE <i>N - D/BAR. N - RAH</i> Hospital / s <i>INVERCLYDE</i> Year / s <i>LAST ADMISSION 1998</i>	
	a) Occupation of patient. b) If retired, enter last normal occupation. c) If under 18 years, or never employed, enter parent's or guardian's occupation d) If married, enter husband's occupation.		Name of General Practitioner <i>DR NUTCH</i> Address <i>DUBBS RD MEDICAL CENTRE PORT GLASGOW</i> Telephone Number	
N E X T O F K I N	NATIONAL HEALTH SERVICE NUMBER		EPILEPSY PRESENT: Yes ☐ No ☒	W A R N I N G S S P E C I A L
	RELIGION <i>PROT</i>		DIABETES PRESENT: Yes ☐ No ☒	
	Name 		SPECIAL HAZARDS (E.G. Drug allergies, etc.) <i>NONE</i>	
	Relatio 		OTHER	
	NATIONAL INSURANCE NUMBER <i>JD 95 23 76A</i>		CHANGE OF STATUS Date	
	PENSION / ALLOWANCE <i>DLA INCOME SUPPORT</i> Type Number		To	
	MONEY AND / OR VALUABLES LODGED Yes / No ☒		DATE OF DISCHARGE Day Month Year	S T Y 0 4 2 0 N
			To	

Argyll & Clyde Health Board

Greater Renfrewshire Division Adult Mental Health

REFERRAL ASSESSMENT

Date Assessed	290106	Time of Assessment (24 Hour)	130 PM
Surname	PHILIPS	G.P. Name	Dr Mitch Michael
Forename & Initial	WESLEY	G.P. Address (No. & Street)	Post Glasgow Surgery
Date of Birth		Town	
Address (No. & Street)	45 Prospect Hill Court	'Phone No.	
Town	GREENOC	Employment Status	MI
Post Code	PA15 4ER	Referred By:	Dr Ameen
'Phone No	01473 800482	Interviewers	1. Dr Adimulan
Social Contact	CHRISTINE SORANPHILIP	Names	2. Chuan
		Admitted Hosp. & Ward	✓ Ward 2
		Not Admitted	

History of Presenting Illness

⇒ Referred by Dr Ameen SMO in Casualty for the assessment of suicidal ideas.

H/o present complaint

⇒ Patient is h/o borderline personality disorder and well known to Inverclyde Royal Hospital.

1) He has been feeling suicidal for 3 months. Not able to tell the reason. Having gone worse since a fortnight. Not able to recognise the reason. Get thoughts about throwing in front of train or jumping out of a window. No attempt made. No plan made. don't know what stopped him. He was asked by his mother to leave the house in the evening. He took 2 vodka at 7.00pm. Things have become worse. He wanted to jump in front of train. But he changed his mind and started sunning and went to train. He had a panic attack. He seemed to R.A.H. checked medically. no problem was identified physically.

2) He says he has suicidal thoughts wants to kill himself. He wants to take an overdose or jump in front of a train or jump from window.

3) Mood has been persistently low for 3 months. worse in the night

↓ Energy - not looking after personal hygiene
 ↓ motivation - not happy at all.
 ↓ appetite - c/o trousers becoming loose.
 c/o Insomnia, no early morning awakenings
 ↓ concentration, guilt, confidence
 Feels hopeless and worthless

No h/o hallucinations
 No h/o delusion.

Modified Sainsbury's Risk Assessment Done:-

Past Psychiatric History

- Borderline personality disorder.
- Saw Dr Deering on Inverclyde. offered day hospital. Aggressive. Evicted from day/hospital.
- multiple h/o overdoses, self harm - To release tension.
- No CPN information.

REFERRAL ASSESSMENT - Continued

Past Medical History

Tourette's Syndrome -

Current & Past Medication

Name	Dose	Frequency	Current/Not Current	Other Information
haloperidol	1.5 mg	tds		
Quetiapine	25 mg	bid		
Citalopram	20 mg	od		
	1 mg	medication	doesn't help	
Alprazolam - Nil				

Family History

Mother	
Father	
Siblings	
Children	ALL

Personal History

Birth/Childhood	
	A documented before
School/Education	

REFERRAL ASSESSMENT - Continued

(Primary/Secondary Qualifications)	
Occupations	
Relationships	⇒ NO w/o relationship before ⇒ Not in relationship before

Family Psychiatric History

NO w/o family mental health issues.

Pre-morbid Personality

Chronic feeling of emptiness, feels abandoned
 Impulsivity @ multiple episodes of self harm
 Fair Argumentative

Social Circumstances

Finances	no debts. Income support. DCA.
Housing	lives w mother. Currently mother sent him out
Childcare	nil
Employment	nil
Smoking	Smoker - 20/day

Illicit Drug usage & Alcohol History

previously tried heroin.
denial of using drugs now.

Drinks once a month vodka. no recent change.
No w/o dependence

C.A.G.E. Questionnaire

Units of Alcohol per week

Forensic History

- Accused for breach of peace
- no prison before
- no present charges.

Effect of Presenting Problem on Daily Living

- ⇒ not able to look after personal hygiene
- ⇒ not able to carry on i ADL

Effect of Presenting Problem on Relationships with Others

→ Becoming irritable to mother

Mental State Examination

Appearance & Behaviour

Casualty dressed, tall, dishevelled, unkempt hair, obese, 120kg,
 back in odd position, maintained eye contact @ Rapport, appropriate
 behaviour

Affect: Objective & Subjective

Subjectively - low
 objectively - restricted

Speech

Spontaneous, coherent, @ Rate, Rhythm

Thought

Form

NAD

Content

plans of suicide
 no delusion

Perceptual Abnormalities

NAD

Cognitive Function

Oriented of place, person and time

Intelligence

NAD

Insight

+++

Summary

23 year old man, w/o borderline personality disorder. Known to JPH, passed from admission, w/o 15 months w/o persistent low mood, no suicidal var. chn, sleep difficulties & Appetite, negative cognition, suicidal thoughts. plan to take an overdose.

Collaborative Information

N/A

Differential Diagnosis

- ① Moderate depressive episode
- ② Borderline personality disorder.

Focus of Patient Care

- ① Admission required for further assessment.

But Inverclyde doctor Dr Gabeer said that they would not admit him. He refused to take the patient many times. He advised us to keep the patient in the pharmacy. He did not listen for the argument. He checked the phone. As per the bed manager chris, Inverclyde staff said that there was a bed but later said that there was no bed. As they refused to take him many times it was difficult to put the patient at risk by sending him there. Hence admission has been given in ward 2 RATH.

- ② general observation
- ③ No regular medication
- ④ Review by Consultant

Discussed with:-

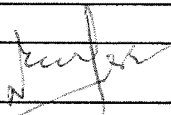
Dr Prinsloo.

Admitted To Ward:- Ward 2 RATH

Not Admitted

Signatures of Assessors

1



2

DYKEBAR HOSPITAL PAISLEY

PHYSICAL CONDITION

NAME

Wesley Phillips

WARD

Date of Examination

29/1/06

Height

Weight

T.

P.

R.

Bruises, Injuries, Deformities, Stigmata

Skin

Hair

Eyes

Physique and General Health

Respiratory

Vesicular, clear

Circulatory

S, S2 @

Condition of arteries

B.P.

140/80 mmHg

Alimentary

Teeth

P.R. - 90/min.

P/A - Soft, NAD

Herniae

Genito-urinary

Urine

Nervous

→ No ↑ Reflex

ⓐ Tone

ⓑ Power

No CPSE

Also plantar B/L down going

Endocrine

Special Findings

Assessment of Physical Condition

Physical examination carried out by

[Signature]

CLINICAL NOTES CONT'D

NAME

UNIT NUMBER

DATE

29/1/06

S.H.D. R. IV.

A.T.S.P. → pain in the Neck

Pt. said pt. is wearing Off:

Presently no pain

No Tenderness

No Restriction of movement

Can easily putting chin on the chest

⇒ Nothing Req

D. Fay

30.1.06:

Inverclyde pt - admitted because

he's on an 'Alert' in Inverclyde and couldn't be admitted there.

Suicidal threats current. Bv 7 yrs - constant fast 3/2. Several spells of IPC in Inverclyde, but to be unhelpful. Attempt made to admit to day unit but he became violent → criminal proceedings underway for damage.

Recently admitted to Gartnavel. Now came to RAH on 28.1.06.

→ Imp is of longstanding difficulties accepting services locally.

Suggest Mx @ London / Secup

→ London for admission not helpful.

→ d/c to G and local Secup - Anger management course in the pipeline.

A. H.

Out Patient Clinical Notes

GP Name
 Address
 Practice Code
 Fundholder Yes / No

Please use patient ID label if available

Name 
 Address **0502823496**
WESLEY PHILLIPS
48 BRAESIDE DRIVE
 Date **BARRHEAD**
 Unit **G78 2QB 05/02/1982**

Date	
12/3/9	Went ft day. uses everyth, looks ok 3 bags heroin today, 3y crack \$90 10 w 11 pipes, 8 pints 4 tickets Saps the heroin 7-8 bags every day last 2-3 months. 3 hrs with 2 part work - other papers Subutex - last 4 w 5 days ago. <i>John J. Jones</i> Dr. Ahmed gave him Zimovane. <i>Yiffy - Max. Bitch</i> feels like going to do robbery. <i>None</i> Very keen to get a rehab. On Verifurine doesn't react for much took it all at once On Laxerol Saps out + went to Vets & got with normal saps in hospital out of prison Sept 08, OK for a couple of months & built on drugs Saps the first day looked psychotic, I woke up & I think my dreams are reality. <i>Apples etc.</i> 30 lbs x 3 16/3 40 lbs x 7 17/3

Date

9/4/9

DNA



7/5/9

out of Levensdale
full of Knapkins - was in his hand, in room
bought 1 lb of vitamin + 2 bps. hair
hair - regular after of Cereals
→ 1 lb of oil this, bps and in the water.
hair pulled - in the
→ 1 netball to 60 lbs

3/6/5

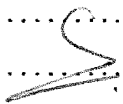
back in own house - dep, no furniture etc
using 3 bps. hair day. N in hands
at day is getting jellies
unhappy, stop to eat
no sps for Levensdale
Stark it is didn't eat any sps
→ net 75 lbs

13/8/5

24/5/5 still N hair 2 bps/day
has a girlfriend, made up
N hair, R hair
→ net 90 lbs
4 lbs

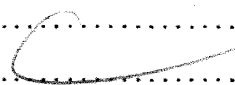


glt - netball pres.



18/5/11

None



CHRONOLOGICAL ACCOUNT OF CARE

PIMS No/CHI No:	LABEL	WARD:
NAME:		
ADDRESS:	80 Balfour Rd	
POST CODE:	Paisley	
DOB & GENDER:	PA 1 340	

0502823496
WESLEY PHILLIPS
48 BRAESIDE DRIVE
BARRHEAD
G78 2QB 05/02/1982

Tel - 570 2692

DATE & TIME	THE CHRONOLOGICAL ACCOUNT OF CARE IS A COMPLETE RECORD OF THE PATIENT'S JOURNEY FROM ADMISSION TO DISCHARGE. IT WILL ENCOMPASS ADMISSION STATEMENTS/DETAILS, EVALUATIONS, UPDATES, REVIEWS, MULTIDISCIPLINARY DECISIONS AND RECORDINGS OUT-WITH FORMAL MDT. EACH ENTRY MUST BE TITLED WITH A HEADING OF THE RECORDINGS. EG CARE PLAN REVIEW, EVALUATION, ONE TO ONE CONTACT. IT IS THE DUTY OF ALL REGISTERED NURSES TO REFER BACK TO THE INTERVENTIONS FOR EVALUATION PURPOSES.	SIGNATURE, PRINT NAME & DESIGNATION
11/10/11	RDS	
	DMS	
12/10/11	Dr - Mgt Parkinson	
	Plan - ? to manage	
		Dr (SB)
14/10/11	RDS	
	Transfer from East Renfrewshire	
	Also heroin including 40, given at in	
	the Port.	
	Was on a/an rehab given at	
	on ? Inpatient	
	Report of self harm in teenage	
	poly drug use	
	On Methadone 35 ml. at value, Cocaine	
	Tramadol.	
	Re Methadone 55 ml, daily	Ther.
	Amphetamine 300mg, 6d	Discontinuing
	was - Phoselone 40mg	WHF.
	Heroin - 3-4 times last 2 bags	Still inject

DATE & TIME	EACH ENTRY MUST BE TITLED WITH A HEADING OF THE RECORDINGS EG. CARE PLAN REVIEW, EVALUATION, ONE TO ONE CONTACT.	SIGNATURE, PRINT NAME & DESIGNATION
	Boredom - no friends / 'mum' gang	
	Discussed anxiety sp, acupuncture	
	stopped at school & 2nd yr. stopped	
	Tremor of voice.	
	SIB in 2009 & psychiatric	
	on Thelma Syd → Personality Disorder	
	↓	
	in Manchester.	
	My improving with ↑ in medication	
	Plan - To give Lisdexamfetamine Syrup	
	for 8 days - Methyladone ↑ to	
	60mg day.	
	- Our Re Sam	
	- Next will see in surgery	
Letter		
	- knew Apr & later.	
		John
		Dr Gordon
		(123)
24/1/12	RDS.	
	Attended. Seen = Next = Tanya	
	Doing well. No night complaints	
	apart from sedation with	
	Quetiapine and falling asleep	
	during day.	
	No Ho auditory hall? Since April 2010	
	No Ho self harm / suicide ideation -	
	similar period. Most - for most of time	

DATE & TIME	EACH ENTRY MUST BE TITLED WITH A HEADING OF THE RECORDINGS EG. CARE PLAN REVIEW, EVALUATION, ONE TO ONE CONTACT.	SIGNATURE, PRINT NAME & DESIGNATION
Contd	- Discussed admission in A&E to 300mg. note them h.d.	
	- No change in other R	
Contd	- Review in 2-3/12	
	- Mgt with condition de support.	
		for [signature]
		Dr [signature]
22/3/12	RDS	
	Seen with Kate in the absence of Mgt.	
	Doing relatively well.	
	Mem of - back of medication	
	CDS in for diagnosis & long period.	
	Discussed with Mgt.	
	Appetite - poor sleep - well. Less food.	
	Discussed with Mgt. - no report.	
	Plan - no change in R	
	- Report with	
	- Review with	
3/5/12	ECG review 1 May 2012 shows ↑ QTc 526 ms ECG 9 Feb 2012 = QTc = 495 ms	Dr [signature] (SR)
	Med = Methadone 60. Quetiapine 150mg. Fluoxetine 20mg	
	OW = M. Parkinson (off today)	
	Discussed with OW Michael Finlay → unable to contact pt on phone but scripts stopped @ chemist tomorrow.	

DATE & TIME	EACH ENTRY MUST BE TITLED WITH A HEADING OF THE RECORDINGS EG. CARE PLAN REVIEW, EVALUATION, ONE TO ONE CONTACT.	SIGNATURE, PRINT NAME & DESIGNATION
	Final Plan - ↓ Meth 10ml ↓ Quetiapine 50mg was -ve for Opiates in recent months Repeat ECG in 2/52. Consider changing to Suboxone.	
4/5/12	DLW Medical Receiving Doctor 9-45am RAH - Russell Allan Advised - Admission not necessary - Stop Quetiapine 10t. - Repeat ECG next week - check Electrolytes esp Ca, Mg, Ph, Kt. - Arrange Cardiac follow up if QTc remains high. Next step also → change to Suboxone.	
4/5/12	11-30 Quetiapine helps = stop + voices - inside heart symptomatic but Obv. - 'heart skipping beats at times' Repeat ECG next Tuesday - pending results of ECG consider change Meth → Suboxone. Plan - Stop Quetiapine Start Dicyclanil 5mg bd. Review 2/52	

CHRONOLOGICAL ACCOUNT OF CARE

PIMS No/CHI No:	LABEL	WARD:	
NAME:	Wesley Phillips		
ADDRESS:			
POST CODE:			
DOB & GENDER:			

DATE & TIME	THE CHRONOLOGICAL ACCOUNT OF CARE IS A COMPLETE RECORD OF THE PATIENT'S JOURNEY FROM ADMISSION TO DISCHARGE. IT WILL ENCOMPASS ADMISSION STATEMENTS/DETAILS, EVALUATIONS, UPDATES, REVIEWS, MULTIDISCIPLINARY DECISIONS AND RECORDINGS OUT-WITH FORMAL MDT. EACH ENTRY MUST BE TITLED WITH A HEADING OF THE RECORDINGS. EG CARE PLAN REVIEW, EVALUATION, ONE TO ONE CONTACT. IT IS THE DUTY OF ALL REGISTERED NURSES TO REFER BACK TO THE INTERVENTIONS FOR EVALUATION PURPOSES.	SIGNATURE, PRINT NAME & DESIGNATION
8/5/12	2004 ECG QTc > 500 STB Dr Henderson - made changes and ECG to be repeated today. Further plan. - To stop thiazide completely. - To ↓ methadone to 50mls from 8/5/12. - To continue Diazepam if necessary. - Repeat ECG in 1 wk time.	
11/6/12	ECG repeated 8/5/12 ↳ Sinus brady = 51 bpm QTc Normal @ 429 ms⁻¹. Bloods all (N) including K⁺, Ca²⁺, Mg, Ph. <u>Plan</u> - Continue Methadone 50ml daily + Diazepam 10mg daily Review Dr. Regan	Dr. Regan (SIS) 

NHS GREATER GLASGOW & CLYDE - MENTAL HEALTH SERVICES

DATE & TIME	EACH ENTRY MUST BE TITLED WITH A HEADING OF THE RECORDINGS EG. CARE PLAN REVIEW, EVALUATION, ONE TO ONE CONTACT.	SIGNATURE, PRINT NAME & DESIGNATION
22/5/12	ROS	
	Rm Melbadon South day	
	Diagnose Sng 6g	
	Mgt - saw mendronid (separated)	
	why heavy problems w/	
	this mood last wk.	
	Fully 'depressed' wanted to die	
	S7B - RSH And this at Disbar	
	at some point.	
	40 stones in addition to housing	
	situation at home, const.	
	case results of grounds murder	
	Mood - a bit down	
	glad to be alive.	
	Denied ongoing suicidal intent / plan	
	look for more evidence / work etc	
	Purposed adding supportive Sng man	
	Diagnose will finish in 3 weeks	
	Plan - To add supportive Sng man	
	- Melbadon same dose	Starts today
	- Review for need for antipsych	
	life Olanzapine Sng made	
	& message in the future	
	- Review next	
		L. J. Jones
		ESR

DATE & TIME	EACH ENTRY MUST BE TITLED WITH A HEADING OF THE RECORDINGS EG. CARE PLAN REVIEW, EVALUATION, ONE TO ONE CONTACT.	SIGNATURE, PRINT NAME & DESIGNATION
26/11/12	POS KW - MP (Fuge - leave) On probation - Loretta this. Mood - down No DSA (current) in day Discussed fully groups. Discussed his drop in of personal disorder and ways of coping and managing large beds. Plan - To ↓ DSA from 20 to 10 x 24h and to stop - See also Melbadeu - To 7 Sustrabau to 100mg day - 24h to report in 1-2/12. - See APP. - Report	
24/12/12	In support across Loretta - Meets area on fire for IV testing Says after IV was claiming to have no motivation, this is bad already tells days all right missing chart as can't get up sheets - ECG, having shot by neck off subcutis, looks well 24h who refer to center	

ROYAL AL

0502823496

PHILLIPS
WESLEY

LABORATORY MEDICINE TELEPHONED REPORT

Patient Name: 05/02/1982 M

Hospital/CHI No: RDS

Date of Birth:

Sex: M F

Doctor: GOVENDER

Date / Time Specimen Taken: 9 / 5 / 12

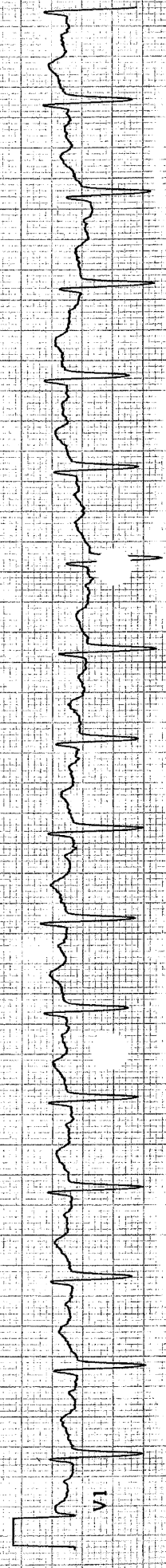
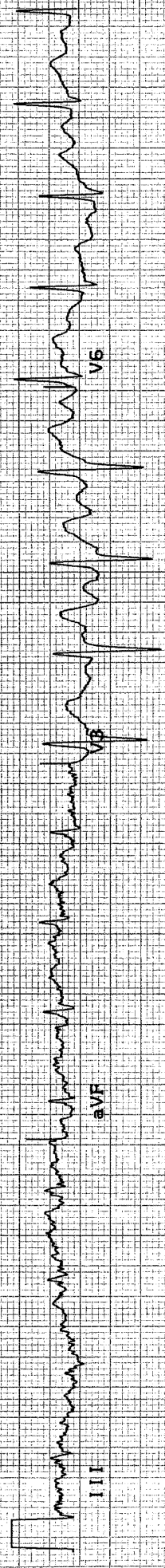
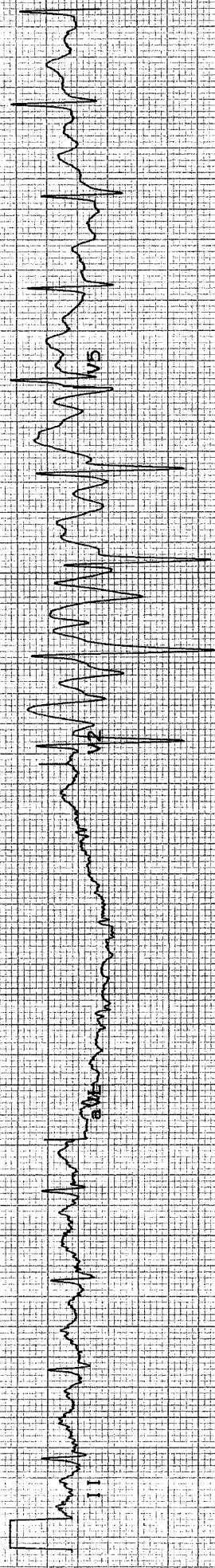
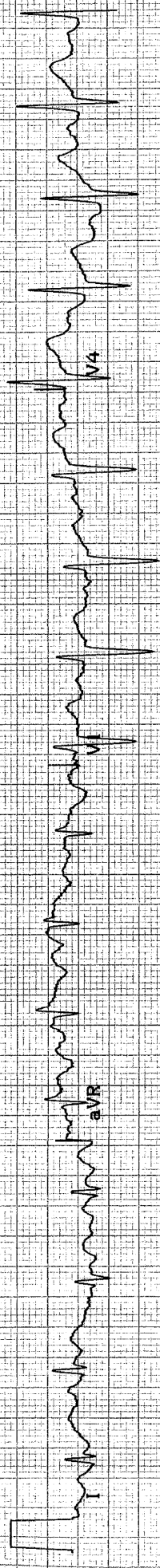
Date / Time Result Phoned: / /

REQUESTED URGENT

Haemoglobin	: 139	g/dl	Prothrombin Time (P.T)	: _____	Secs
White Cell Count:	7.9	10 ⁹ /l	A.P.T.T.	: _____	Secs
Platelets	: 274	10 ⁹ /l	Fibrinogen	: _____	mg/dl
MCV	: _____	fl	INR (Warfarin)	: _____	Ratio
Neutrophils	: 4.4	10 ⁹ /l	APTT (Heparin)	: _____	Secs
Comments: Folate 4.2 feritin 85 V1 + B12 358					

Biochemistry Results				Ref. Values				Ref. Values			
1	Plasma Glucose		mmol/l	(F) 4.3 - 5.9	19	Serum Amylase	U/l	<100			
2	Serum Sodium	139	mmol/l	135 - 145	20	Serum CRP	mg/l	<5			
3	Serum Potassium	4.5	mmol/l	3.5 - 5.0							
4	Serum Chloride	110	mmol/l	97 - 107	21	Serum Calcium	2.32	mmol/l			
5	Serum Bicarbonate	22	mmol/l	23 - 30	22	Calcium Adj for Alb.	2.42	mmol/l	2.25 - 2.60		
6	Serum Urea	5.4	mmol/l	2.5 - 7.5	23	Serum Phosphate	0.91	mmol/l	0.8 - 1.4		
7	Serum Creatinine	66	umol/l	62 - 124	24	Serum Magnesium	0.96	mmol/l	0.7 - 1.1		
8	Serum Protein	69	g/l	62 - 82	25	Serum Urate		mmol/l	0.12 - 0.42		
9	Serum Albumin	37	g/l	37 - 50							
	GLOB	32			26	[H+]		nmol/l	38 - 43		
10	Serum Alk. Phos.	109	U/l	33 - 117	27	PaCO2		kPa	4.6 - 6.0		
					28	PaO2		kPa	10.5 - 13.5		
11	Serum Bilirubin	4	umol/l	<19	29	Bicarbonate		mmol/l	21 - 25		
12	Conj Bilirubin		umol/l	<20	30	Base Excess		mmol/l	- 3 - + 3		
13	Serum AST	44	U/l	13 - 42	31	Urine Osmolality		mOsmol/l			
14	Serum ALT	62	U/l	11 - 55	32	Serum Osmolality		mOsmol/l	275 - 295		
15	Serum LDH		U/l	240 - 480							
					33	Serum Paracetamol		mmol/l			
16	Serum CK		U/l	<190	34	Serum Salicylate		mmol/l			
17	Serum Troponin-T		ug/l	<0.05							
					35	CSF Protein		g/l	0.15 - 0.45		
18	Serum GGT	360	U/l	8-60	36	CSF Glucose		mmol/l	2.2 - 4.4		

25mm/s
10mm/mV
40Hz
Pgm 0100/v78
Cart: 4
Med: 05-FEB-1980 Ht: Wt:
Sex: M Race: Cauc
Loc: 9 Room:
Vent. rate 100 BPM
PR interval 184 ms
QRS duration 92 ms
QT/QTc 380/487 ms
P-R-T axes 75 78 51
Tech: Referred by: Unconfirmed



ROYAL ALEXANDRA HOSPITAL

ACCIDENT / EMERGENCY NURSING RECORD

Wesley Phillips

TRIAGE	DATE: 18/1/85 TIME: 2055
FLOWCHART	chest pain
DISCRIMINATOR	pleuritic
CATEGORY	Y
NURSE	1/2
E.N.P. CRITERIA	YES/NO

HISTORY OF PRESENTATION/IMMEDIATE TREATMENT

999 call re pleuritic chest pain
 pt feels suicidal - hx of personality disorder
 has not taken today's medication

PAIN SCORE:	1	2	3	4	5	6	7	8	9	10
ANALGESIA	DOSE		ROUTE		SIGNATURE		TIME 24HR CLOCK		GIVEN BY	

Signature	Time	BP	Pulse	Temp	Resp	SAT O ₂	PEFR	BM	Urinalysis	
GA	: hrs	111/35	101		20	94%			H.C.G	
	: hrs									
	: hrs									
	: hrs									
	: hrs								Visual Acuity	
	: hrs								R	L
	: hrs									
NEXT OF KIN INFORMED: YES/NO				TIME: : HRS			IN ATTENDANCE: YES/NO			
NAME & STATUS OF ACCOMPANYING ADULT										

CHI
Number
0502823496CRN
DYK050282349 IRH195834Surname
PHILLIPSSex
MaleForename
WESLEYDate of Birth
05/02/1982Clinical Details
No clinical details provided.Patient
Address
**80 BALFRON ROAD
PAISLEY**Clinician
DR C MCMAHONAddress
**Renfrewshire Drug Service
Renfrewshire Drug Service
10 St. James Street
Paisley
PA3 2HT**Laboratory Ref.
BC401624Page
1 of 1

Amphetamines	Negative
Benzodiazepine	Negative
Methadone	Positive
Opiates	Positive
Cocaine	Negative
Urine Creat.	22.70

* mmol/L (0.30 - 15.0)

Authorised by Duty Clinician/Scientist

Normal Adult Reference Ranges are for Guidance Only. They do not take into account age difference.

Date / Time Received 26/04/2012 10:28
Date / Time Reported 27/04/2012 09:30

BIOCHEMISTRY

DRUG REPORT

Date / Time Collected
23/04/2012 u/k

Page 1 of 1

CHI
Number
0502823496CRN
DYK050282349 IRH195834Surname
PHILLIPSSex
MaleForename
WESLEYDate of Birth
05/02/1982Clinical Details
ix methadonePatient
Address
**80 BALFRON ROAD
PAISLEY**Clinician
UnknownAddress
**Renfrewshire Drug Service
Renfrewshire Drug Service
10 St. James Street
Paisley
PA3 2HT**Laboratory Ref.
BC371919NPage
1 of 1

Amphetamines	Negative
Benzodiazepine	Positive
Methadone	Positive
Opiates	Negative
Cocaine	Negative
Urine Creat.	24.60

* mmol/L (0.30 - 15.0)

Authorised by Duty Clinician/Scientist

Normal Adult Reference Ranges are for Guidance Only. They do not take into account age difference.

Date / Time Received 29/03/2012 12:35
Date / Time Reported 30/03/2012 09:30

BIOCHEMISTRY

DRUG REPORT

Date / Time Collected
27/03/2012 11:00

Page 1 of 1

CHI Number **0502823496** Patient Address **39 SUNNYSIDE PLACE BARRHEAD GLASGOW G782RT** Clinician **DR C MCMAHON**
CRN **DYK050282349 IRH195834** Address **Renfrewshire Drug Service Renfrewshire Drug Service 10 St. James Street Paisley, PA3 2HT**
Surname **PHILLIPS** Sex **Male**
Forename **WESLEY** Date of Birth **05/02/1982**

Clinical Details **No clinical details provided.**

Laboratory Ref.
BC301332B

Page
1 of 1

Amphetamines	Negative		
Benzodiazepine	Positive		
Methadone	Positive		
Opiates	Negative		
Cocaine	Negative		
Urine Creat.	22.30	* mmol/L	(0.30 - 15.0)

Normal Adult Reference Ranges are for Guidance Only. They do not take into account age difference.

Date / Time Received 30/01/2012 11:41
Date / Time Reported 31/01/2012 09:30

BIOCHEMISTRY**DRUG REPORT**

Date / Time Collected
24/01/2012 u/k

Page 1 of 1

CHI Number **0502823496** Patient Address **39 SUNNYSIDE PLACE BARRHEAD GLASGOW G782RT** Clinician **DR C MCMAHON**
CRN **DYK050282349 IRH195834** Address **Renfrewshire Drug Service Renfrewshire Drug Service 10 St. James Street Paisley, PA3 2HT**
Surname **PHILLIPS** Sex **Male**
Forename **WESLEY** Date of Birth **05/02/1982**

Clinical Details **No clinical details provided.**

Laboratory Ref.
BC326063A

Page
1 of 1

Amphetamines	Negative		
Benzodiazepine	Positive		
Methadone	Positive		
Opiates	Negative		
Cocaine	Negative		
Urine Creat.	26.20	* mmol/L	(0.30 - 15.0)

Authorised by Duty Clinician/Scientist

Normal Adult Reference Ranges are for Guidance Only. They do not take into account age difference.

Date / Time Received 20/02/2012 12:26
Date / Time Reported 21/02/2012 09:30

BIOCHEMISTRY**DRUG REPORT**

Date / Time Collected
u/k u/k

Page 1 of 1

CHI Number **0502823496**
CRN **DYK050282349 IRH195834**
Surname **PHILLIPS** Sex **Male**
Forename **WESLEY** Date of Birth **05/02/1982**

Patient Address **39 SUNNYSIDE PLACE
BARRHEAD
GLASGOW
G782RT**
Clinician **DR C MCMAHON**
Address **Renfrewshire Drug Service
Renfrewshire Drug Service
10 St. James Street
Paisley
, PA3 2HT**

Clinical Details **FULL DRUG SCREEN**

Laboratory Ref.
BC170193P

Page
1 of 1

Amphetamines	Negative		
Benzodiazepine	Positive		
Methadone	Positive		
Opiates	Negative		
Cocaine	Negative		
Urine Creat.	20.70	* mmol/L	(0.30 - 15.0)

Normal Adult Reference Ranges are for Guidance Only. They do not take into account age difference.

Date / Time Received 07/10/2011 11:38
Date / Time Reported 08/10/2011 09:30

BIOCHEMISTRY**DRUG REPORT**

Date / Time Collected
04/10/2011 u/k

Page 1 of 1

CHI Number **0502823496**
CRN **DYK050282349 IRH195834**
Surname **PHILLIPS** Sex **Male**
Forename **WESLEY** Date of Birth **05/02/1982**

Patient Address **39 SUNNYSIDE PLACE
BARRHEAD
GLASGOW
G782RT**
Clinician **DR C MCMAHON**
Address **Renfrewshire Drug Service
Renfrewshire Drug Service
10 St. James Street
Paisley
, PA3 2HT**

Clinical Details **No clinical details provided.**

Laboratory Ref.
BC190008A

Page
1 of 1

Amphetamines	Negative		
Benzodiazepine	Positive		
Methadone	Positive		
Opiates	Negative		
Cocaine	Negative		
Urine Creat.	18.30	* mmol/L	(0.30 - 15.0)

Normal Adult Reference Ranges are for Guidance Only. They do not take into account age difference.

Date / Time Received 21/10/2011 10:15
Date / Time Reported 22/10/2011 09:30

BIOCHEMISTRY**DRUG REPORT**

Date / Time Collected
19/10/2011 u/k

Page 1 of 1

CHI
Number **0502823496**
CRN **DYK050282349 IRH195834**
Surname **PHILLIPS** Sex **Male**
Forename **WESLEY** Date of Birth **05/02/1982**

Patient
Address **48 BRAESIDE DRIVE
BARRHEAD
GLASGOW
G782QB**

Clinician **Unknown**
Address **SUBSTANCE MISUSE TEAM
SUBSTANCE MISUSE TEAM
113 Cross Arthurlie Street
Barrhead
, G78 1EE**

Clinical
Details **POLY DRUG USE**

Laboratory Ref.
BC382846D

Page
1 of 1

Amphetamines	Negative	
Benzodiazepine	Positive	
Methadone	Negative	
Opiates	Positive	
Cocaine	Negative	
Urine Creat.	>32.0	mmol/l

Normal Adult Reference Ranges are for Guidance Only. They do not take into account age difference.

Date / Time Received 17/03/2009 12:46
Date / Time Reported 19/03/2009 09:30

BIOCHEMISTRY

DRUG REPORT

Date / Time Collected
16/03/2009 11:50

Page 1 of 1

20 Back Sneddon Street
PAISLEY PA3 2DJ

Our Ref: LR/DC/CHI 0502823296
Date: 13th August 2012

Renfrewshire Drug Service
Direct: 0141-889-1223
Fax: 0141-848-9776

Date Dictated: 30th July 2012

PRIVATE & CONFIDENTIAL

Dr. Mitchell
The Levern Medical Group
Barrhead Health Centre
213 Main Street
BARRHEAD G78 1SW

Dear Dr. Mitchell

Wesley Phillips (0502823496)
Loretto Housing Association, 17 Abercorn Street, Paisley

Psychiatric Diagnosis: F11.2 – Opiate Dependence, Personality Difficulties with reports of self-harm, Prolonged QTc Interval

Current Psychotropic Medication: Methadone 50 mls. daily, Sertraline 100 mgs. daily, Diazepam reduced to 5 mgs. nocte for two weeks only and then to stop.

My apologies for the delay in this letter.

I reviewed Mr. Phillips at Renfrewshire Drug Service on 26.06.2012 with Michael Finlay, a staff member, as his key worker Margaret Parkinson was on leave. Mr. Phillips briefly mentioned the difficulties he was having in the recent past and told us that he was on probation. He has also moved to Loretto Housing and we discussed ways of structuring his days more effectively while he is there. He reported his mood as a bit down. Considering the difficulties he was having recently I was not surprised. During that meeting he denied any ongoing suicidal ideation and appeared more positive and optimistic about his future. We discussed the diagnosis of personality disorder and ways of coping with his illness and managing things better, rather than presenting in crisis repeatedly. He appeared keen to join our fishing group to occupy his time better. We also discussed the implications of ongoing use of Diazepam and agreed that the dose would be reduced to 5 mgs. nocte for two weeks and to stop completely afterwards.

Cont'd/... ..

Page 02
Wesley Phillips

Dr. Mitchell
Levern Medical Group

I have not made any changes in his Methadone dose and it has continued at 50 mls. daily. However, considering the difficulties he was having with his mood, I have agreed to an increase in his dose of Sertraline to 100 mgs. daily.

He has had problems with his ECG in the past and there is a family history of cardiovascular illness. Considering all this, I agreed that his ECG would be repeated in about a month's time. He will be reviewed at Renfrewshire Drug Service in due course and I will make changes to his medication as agreed today.

Yours sincerely

Dr. Lovely Rajan
ST5 in Addiction Psychiatry

Dr. Charles McMahon
Consultant Psychiatrist

20 Back Sneddon Street
PAISLEY PA3 2DJ

Our Ref: CG/KAC/CHI 0502823296

Date: 17th May 2012

Date Dictated: 11th May 2012

Renfrewshire Drug Service
Direct -0141-889-1223
Fax 0141-848-9776

PRIVATE & CONFIDENTIAL

Dr. Mitchell
The Levern Medical Group
Barrhead Health Centre
213 Main Street
BARRHEAD G78 1SW

Levern
Sugartown accommodation
17 Oberstone St
Paisley

Dear Dr. Mitchell

Wesley Phillips (0502823496)
80 Balfron Road, Paisley PA1 3DH

I am writing to inform you of the latest progress with Mr Phillips. His Quetiapine medication was stopped altogether and so was his Fluoxetine anti-depressant. He received a repeat ECG on 08 May 2012 which revealed a sinus bradycardia of 51 bpm and a QTc level of 429 m.s – which is now within normal limits. His bloods were also checked on 08 May 2012 which revealed essentially normal findings including a normal calcium, magnesium and phosphate level. His current prescriptions are for Methadone 50 mls daily and Diazepam 10 mgs daily. He will be reviewed in due course by Dr Rajan and we will update you on his progress with the Drug Service.

Yours sincerely

Dr Christopher Govender
Specialty Doctor
Addiction Psychiatry

Dr Charles McMahon
Consultant Psychiatrist

10 St. James Street
PAISLEY PA3 2HT

Our Ref: CG/DC/CHI 0502823296

Date: 15th May 2012

Date Dictated: 4th May 2012

Renfrewshire Drug Service
Direct -0141-889-1223
Fax 0141-848-9776

PRIVATE & CONFIDENTIAL

Dr. Mitchell
The Levern Medical Group
Barrhead Health Centre
213 Main Street
BARRHEAD G78 1SW

Dear Dr. Mitchell

Wesley Phillips (0502823496)
80 Balfon Road, Paisley PA1 3DH

Psychiatric Diagnosis: F11.2 – Opiate Dependence, Personality Difficulties with previous self-harm, Prolonged QTc Interval

Current Psychotropic Medication: Methadone 60 mls. daily supervised, Fluoxetine 20 mgs. daily, Diazepam 5 mgs. twice daily (commenced today) (Quetiapine discontinued)
(Shun) (Shun)

I reviewed this patient's ECG at the Drug Service on 03.05.2012, which was performed at the RAH on 01.05.2012. It revealed a QTc Interval of 526 m.s. I note that an ECG performed on 09.02.2012 revealed a QTc Interval of 495 m.s. Shortly after the first ECG in February, his Quetiapine was halved to 150 mgs. daily. I discussed with his drug worker Michael Finlay to contact the patient, but he was unable to do so. We managed to stop his prescriptions at the chemist and he attended to see me the following day on 04.05.2012. [REDACTED]

[REDACTED]
[REDACTED] Regarding symptoms, he tells me that he has noticed his heart "skipping beats at times", but was otherwise asymptomatic. He is an obese patient. He has a history of deliberate self-harm and this is clearly evident by the number of old scars on both upper limbs.

Cont'd/... ..

He tells me that his Quetiapine helped with his self-harm, which he has not done for a while. He also described voices within his head that have a derogatory theme, that were being controlled with Quetiapine. He did not present with any obvious psychotic features at his appointment today and appeared to be euthymic and reactive in mood. I also contacted the medical receiving doctor at the RAH, Dr. Russell Allan regarding this patient's ECG. He advised me that admission to hospital was not necessary and that it would be best to stop the Quetiapine in the first instance. He also recommended to check his electrolytes, especially calcium, magnesium, phosphate and potassium. I have discussed this with the patient and with his approval I have stopped his Quetiapine medication today. Instead, I have commenced him on Diazepam 5 mgs. twice daily, for anxiety and agitation, and also due to its good side-effect profile on the heart. His bloods will be repeated in due course and we have arranged for a repeat ECG in approximately four days time. Should his QTc Interval remain elevated we will consider changing his Methadone to Suboxone maintenance treatment. We will also arrange for cardiology follow up if necessary. We will keep you updated on this patient's progress at the Drug Service.

Yours sincerely

Dr Christopher Govender
Specialty Doctor
Addiction Psychiatry

Dr Charles McMahon
Consultant Psychiatrist

10 St. James Street
PAISLEY PA3 2HT

Our ref. LR/DC/CHI 0502823496

Renfrewshire Drug Service
Direct – 0141-889-1223
Fax: 0141-848 9776

Date: 3rd April 2012

Date Dictated: 27th March 2012

PRIVATE & CONFIDENTIAL

Dr. Mitchell
The Levern Medical Group
Barrhead Health Centre
213 Main Street
BARRHEAD G78 1SW

Dear Dr. Mitchell

Wesley Phillips (0502823496)
80 Balfour Road, Paisley PA1 3HD

Psychiatric Diagnosis: F11.2 – Opiate Dependence

Current Psychotropic Medication: Methadone 50 mls. daily, Fluoxetine ²⁰40 mgs. daily,
Quetiapine 300 mgs. nocte.

I reviewed Mr. Phillips at Renfrewshire Drug Service on 27.03.2012 with his key worker Kate Somerville as Margaret Parkinson was dealing with another emergency. He appeared reasonably well and had reported reducing his Quetiapine medication to once daily was helpful. He still complained of lack of motivation during the day and we spoke of the importance of structuring his day more effectively. We also discussed the urine drug screens as Benzodiazepine positive for the last few times and the implications this might have on his mood. He denied using any other illicit substances, including alcohol. He appeared relatively well at the interview and did not offer any other major concerns or complaints. We once again discussed the importance of sleep hygiene, regular exercise and healthy diet on his physical and mental well being. He will be monitored and supported by Margaret Parkinson and another medical appointment will be arranged in due course.

Yours sincerely

Dr. Lovely Rajan
ST5 In Addiction Psychiatry

Dr. Charles McMahon
Consultant Psychiatrist

10 St. James Street
PAISLEY PA3 2HT

Our ref: LR/EM/CHI 0502823496
Date dictated: 9th January 2012
Date: 10th January 2012

Renfrewshire Drug Service
Direct – 0141-889-1223
Fax: 0141-848-9776

PRIVATE & CONFIDENTIAL

Dr Mitchell
The Levern Medical Group
Barrhead Health & Care Centre
213 Main Street
Barrhead G78 1SW

Dear Dr Fitzpatrick

Wesley Phillips Date of birth 05 02 82
80 Balfron Road PAISLEY PA1 3HD

Psychiatric Diagnosis: ICD 10: F11.2 Opiate dependence
Current Psychotropic Medication: Methadone 55 mls, Fluoxetine 40 mgs daily,
Quetiapine 300 mgs nocte (reducing from 300 mgs twice daily to once daily from 9th
February)

.....
I reviewed Mr Phillips at Renfrewshire Drug Service on the 24th January 2012 with his key worker Margaret Parkinson. He appeared relatively well and his only complaint was sedation during the day as he was taking Quetiapine 300 mgs twice daily. He admits that Quetiapine was started some time ago when he suffered from auditory hallucination but he denied any such experience since August 2011. He also reported that his mood was relatively fine and did not have any self-harm or suicidal ideation thoughts since similar time. We discussed the option of reducing his Quetiapine from 300 mgs twice daily to once daily which he was happy with. I have not made any other changes to his medication or management plan. We also discussed the importance of occupying his day time, having a sleep routine and sleep hygiene. I will try to review him in 2 to 3 months time. Meanwhile his key worker Margaret Parkinson will continue to monitor and support him as usual.

Yours sincerely

Dr Lovely Rajan
ST5 in Psychiatry

Dr Charles McMahon
Consultant Psychiatrist

10 St. James Street
PAISLEY PA3 2HT

Our ref: LR/EM/CHI 0502823496
Date dictated: 8th November 2011
Date: 10th November 2011

Renfrewshire Drug Service
Direct – 0141-889-1223
Fax: 0141-848-9776

PRIVATE & CONFIDENTIAL

Dr Mitchell
The Lavern Medical Group
Barrhead Health & Care Centre
213 Main Street
Barrhead G78 1SW

Dear Dr Fitzpatrick

Wesley Phillips Date of birth 05 02 82
80 Balfour Road PAISLEY PA1 3HD

Psychiatric Diagnosis: ICD 10: F11.2 Opiate dependence
Current Psychotropic Medication: Methadone 55 mls, Fluoxetine 40 mgs daily,
Quetiapine 300 mgs BD

.....
I met with Mr Phillips on the 8th November 2011 at the Renfrewshire Drug Service with his key worker Margaret Parkinson. He had been transferred from East Renfrewshire Drug Service and has been using Heroin intravenously. He told me that he also had a diagnosis of Tourette's syndrome in the past but this had been changed to a personality disorder later on. His recent medication was Methadone 55 mls daily, Quetiapine 300 mgs twice daily and Fluoxetine 40 mgs daily, twice weekly dispensed apart from Methadone which was daily dispensed. He is still using Heroin 3 or 4 times a week and still injecting at times. He spoke of boredom but Margaret has discussed possible attendance in the current group at RDS including anxiety group as well as for acupuncture. He told us that he stopped using street Valium, Tramadol and Cocaine almost 2 weeks ago.

As he was keen to increase his Methadone slightly I have agreed to increase to 60 mls daily and he will have a script until the next run. I have not made any other changes to his medication. I will review him in about 4 months time meanwhile his key worker Margaret will continue to see him for support

Yours sincerely

Dr Lovely Rajan
ST5 in Psychiatry

Dr Charles McMahon
Consultant Psychiatrist

Parkinson, Margaret

From: McEwan, Elaine
Sent: 02 November 2011 15:30
To: Parkinson, Margaret
Subject: RE WP

Plan file
u

Hi Margaret

Wesley is due in to see me tomorrow for his last clinic appt, we will provide him with a methadone prescription 55mgs x 6 days (DDUS TH Sat for Sun) this will cover to the 8-11-11, he will require a new script starting 9-11-11. He will also be given a script for quetiapine 300mg BD x 14 days and fluoxetine 40mgs x 14 days (dispense weekly on a thurs). I will call you to confirm that he attended.

Regards

Elaine McEwan
Senior Addiction Nurse
East Renfrewshire CAT
St Andrews House
Barrhead

Tel no: 0141 577 4685/4027

10 St. James Street
PAISLEY PA3 2HT

Our ref: LR/EM/CHI 0502823496
Date dictated: 11TH October 2011
Date: 13TH October 2011

Renfrewshire Drug Service
Direct – 0141-889-1223
Fax: 0141-848-9776

PRIVATE & CONFIDENTIAL

Dr Mitchell
The Levern Medical Group
Barrhead Health & Care Centre
213 Main Street
Barrhead
G78 1SW

Dear Dr Fitzpatrick

Wesley Phillips Date of birth 05 02 82
80 Balfour Road PAISLEY PA1 3HD

Mr Phillips did not attend the appointment arranged at RDS on the 11th October 2011. His key worker Margaret Parkinson was trying to get hold of him and eventually found out that he had another appointment through East Renfrewshire Drug Service for next Thursday and his Methadone prescription will be continued for the meantime. Margaret will try to see him again in the near future and I will rearrange another appointment in due course.

Yours sincerely

Dr Lovely Rajan
ST5 in Psychiatry

Dr Charles McMahon
Consultant Psychiatrist

Mental Health Partnership

Forensic Directorate

Leverndale Hospital
510 Crookston Road
GLASGOW
G53 7TU

Tel - 0141 211 1375

NHS

Greater Glasgow
and Clyde

Mental Health Team
HMP Barlinnie
Provanmill
GLASGOW
G33 2QX

Date 12 January 2010
Your Ref
Our Ref AP/FMcG
Direct Line
Mobile
Fax
Email

Dear Colleague

WESLEY PHILLIPS – SPIN – 65184 – DOB 5/2/82 – CHI 050 282 3496

I reviewed Mr Phillips at HMP Barlinnie on 12 January 2010 where he is currently on remand for alleged assault. Mr Phillips is known to the Renfrewshire Drug Service and other psychiatric services with a past history of poly-substance misuse, likely alcohol dependence and has also had episodes of suicidal ideation, low mood and possible auditory hallucinations although these seem to be in the context of personality disorder.

Past Medical History

Mr Phillips has had numerous admissions to psychiatric services since the age of 16. These admissions have been short and in times of social crisis. His last admission was at the end of December 2009 when he self-discharged after a couple of days. He said he was admitted because he was feeling very anxious due to problems with his ex-girlfriend. He has also been known to Dr Leighton of Child and Adolescent Services at Inverclyde Royal Hospital. He was reviewed there from the ages of 9 to 16. He was put on Haloperidol for Tourette's Syndrome and ADHD. He was also reviewed by Dr Richards at Queen Elizabeth Hospital, Birmingham from the age of 16 to 22 for Tourette's Syndrome. He no longer suffers from any symptoms of Tourette's Syndrome.

Forensic History

Mr Phillips was a little vague about his forensic history although told me he had had "a good few" times in prison. He said he had 14 months in prison and was released last September. This was for robbery of a shop armed with a knife. He has also been arrested in the past for possession of a knife, breach of the peace and Police assault. He was first arrested at the age of 16 after he attempted to hit his mum and dad with a pick axe.

Drug and Alcohol History

Mr Phillips is currently known to Dr McMahon at Renfrewshire Drug Service and has a key worker, Ms Elaine McGowan at St Andrew's House. He is currently maintained on Methadone. He told me he last used heroin on 18 November 2009 when he injected two £10 bags per day. This was on top of his Methadone. He was also using 15 to 20 street valium tablets per day and occasionally using cocaine. He said he used this when he had the money for about two years. He also described an addiction to crack cocaine two years ago when he mother died. He said he first used cannabis at the age of 9 although has not used that for years.

He occasionally uses alcohol although he denied drinking for months prior to his arrest. He said he has a history of DTs and has had out-patient detox on Librium from his GP.

Personal History

He was born in Germany as his dad was in the Army. There are no known birth complications or developmental delays. He described his childhood as "happy" with no violence in the household:

Mr Phillips believes the problems with his behaviour started at the end of primary school when he fought a lot with his mum and dad. He would also smash up the house and his dad's car. He had a social worker and attended the Children's Panel at the age of 14. He also went into a children's home at the age of 14 as his parents were unable to cope with his behaviour and he went to jail for a few hours whilst staying at the children's home as he smashed up the home. He left to go back to his parents at the age of 15. He was suspended from school on numerous occasions because of difficulties with his behaviour although he denied truanting and said he left school with 7 Standard Grades. He has always lived at home although for the past year he has had his own council house but he has now given that up. He said he will go to live with his father on release from prison. He has worked on building sites with his father and temporary jobs over the years but has not done so for some time.

Family History

There is no known psychiatric history in the family. He has two older brothers who live in Wales and Port Glasgow. He has infrequent contact with them. His mother died three years ago and this was a difficult time for him. He still sees his father. He has no children and is not currently in a relationship.

Medication

He is currently maintained on Quetiapine 200-mgs twice daily, Mirtazapine 30-mgs. He said he never takes these when he is in the community as he feels they will reduce the effects of the heroin. He is, however, taking them in prison although he has not noticed any improvement on these medications.

Mental State Examination

Mr Phillips seemed calm and settled. He was pleasant enough during interview. He was not agitated or anxious. He did describe feeling anxious and low with "thoughts jumping about my head" ... "hundreds of bad stuff going through my head". He did not appear to have any evidence of clinical depression and his sleep and appetite have been stable during his time in prison. He did not display any formal thought disorder. He had no specific thoughts of self-harm and had no current thoughts about life not being worth living. There was an episode on 11/1/10 where he put his head under the water in a sink and heard a voice in his own mind; however, he was unable to elaborate on this experience. He has had many experiences like this over the years and he notably had many self-harm scars over his arms and neck. There were no other potentially psychotic phenomena. He had little insight into the effect of drugs and alcohol on his mental state. He had little insight into the effect of non-compliance with his medication. He has a tendency not to take responsibility for his own actions although he does comply with Drug Service appointments when he is in the community, in his opinion.

Psychiatric assessment of Wesley Phillips – CHI 050 282 3496

Page 3

Mr Phillips seems to have ongoing issues with impulsivity and difficulty coping with difficult events. He finds it hard to control his emotions. It seems that his symptoms could be related to Borderline Personality with Dissocial Traits and alcohol and drug problems. However, we will request his previous notes and will see him again in the prison in one month's time. I did not make any changes to his medication on 12/1/10.

Yours sincerely



Dr ANDREA PERRY
ST3 in Psychiatry

cc : Dr McMahon, Renfrewshire Drug Service ✓
Ms E McGowan, St Andrew's House, Barrhead

Mental Health Partnership



Forensic Community Mental Health
Team
Clutha House
120 Cornwall Street South
Kinning Park
Glasgow
G41 1AD



Private and Confidential

Dr Linden
Inverclyde Community Mental Health Team
128 Cathcart Street
Greenock
PA15 1BQ

Date	24 th November 2009
Your Ref	
Our Ref	
Direct Line	0141 427 8277 / 8279
Mobile	
Fax	0141 427 8278
Email	pauline.mcintosh@ggc.scot.nhs.uk

Dear Dr Linden

Re: Wesley Phillips DOB 05/02/82, 39 Sunnyside Place, Barrhead

I saw your patient on 23rd November 2009 as part of our court liaison service we provide to the Procurator Fiscal at Greenock Sheriff Court. I believe he has longstanding drug misuse problems and admitted to taking heroin and benzodiazepines the day before his arrest for Breach of the Peace.

He presented himself at Accident and Emergency at Inverclyde Royal Hospital for admission after feelings of suicide but was not admitted after assessment. Whereby he hung about the hospital premises before kneeling in the middle of the road outside the hospital. Prior to this he said he had tried to hang himself with a battery charger and flush his head down the toilet. He was arrested unharmed and taken to the local Police Station.

On assessment, his recent history was of falling out with his girlfriend who called him an "obsessive weirdo" and was concerned for his family's good name if she were to gossip about their relationship. He was very vague about why he travelled to Inverclyde for assessment, all the way from Paisley, only saying he was from Port Glasgow.

There was no evidence of distraction nor preoccupation and he was able to respond appropriately to questions. He again was vague about what he would do if liberated and stated "oh I don't know what I'll do".

He wanted to remain in jail to get his "head straight" and told me that he had owned up to an armed robbery which should get him remanded.

He denied any self harm or suicidal ideation at that time but, as I say, was vague and guarded about his future plans.

I discussed him with Dr Macdonald over the telephone and we both agreed that as he was not exhibiting any signs of mental disorder at that time, there was no reason for further assessment by him.

He is currently on Methadone, prescribed by Dr McMahon but he has been using Street Diazepam also. He denied any alcohol use.

After my interview with him I was made ware that he was to receive a Procurator Fiscal liberation after I had saw him.

Delivering better health

www.nhsggc.org.uk

The Police, due to his earlier disclosure of a robbery collected him to be questioned further at Greenock Police Station.

I would hope that he will re-engage with local services when liberated but, I am unsure now as to when that will be.

I do hope you find this information helpful.

Yours sincerely

A handwritten signature in black ink, appearing to be 'Chris O'Brien', with a long, flowing horizontal line extending to the right.

Chris O'Brien
Forensic Community Psychiatric Nurse

cc: Dr Ahmed, GP, Barrhead Health Centre
✓ Dr McMahon, Consultant Psychiatrist, Renfrew Drugs Service

10 St. James Street
PAISLEY PA3 2HT

Our ref. CMCM/DC/CHI 050282
3496

Renfrewshire Drug Service

Direct - 0141-889-1223
Fax: 0141-848 9776

Date: 30th June 2009

Dictated: 2nd July 2009
Typed: 30th June 2009

PRIVATE & CONFIDENTIAL

Dr. Fitzpatrick
The Levern Medical Group
Barrhead Health Centre
201 Main Street
BARRHEAD G78 1SA

Dear Dr. Fitzpatrick

Wesley Phillips (0502823496)
48 Braeside Drive, Barrhead G78 2QB

I saw Wesley at the Drug Clinic on 30.06.2009. Wesley looked very unkempt today and slightly glazed. He says that his house is in a dreadful state with dampness and no electricity and so on. He sold his furniture in some kind of belief that he was going to rehab. Staff will try and support him with that. More worryingly he is continuing to inject up to three bags of Heroin a day and to take Valium and Temazepam. I have warned, particularly about the effects of Benzodiazepines, on his mood. I have increased his Methadone up to 75 mls. daily and he is maintained on that plus Quetiapine 200 mgs. daily and Mirtazepine 30 mgs. at night. I will let you know how things progress.

Yours sincerely

Dr. Charles McMahon
Consultant Psychiatrist

c.c. Alison Fletcher, St. Andrews House
Dr. Mathias, Leverndale Hospital

13/8 DNA

10 St. James Street
PAISLEY PA3 2HT

Our ref. CMC/DC/CHI 050282
3496

Renfrewshire Drug Service

Direct - 0141-889-1223
Fax: 0141-848 9776

Date: 8th May 2009

Date Dictated: 7th May 2009
Date Typed: 8th May 2009

PRIVATE & CONFIDENTIAL

Dr. Fitzpatrick
The Levern Medical Group
Barrhead Health Centre
201 Main Street
BARRHEAD G78 1SA

Dear Dr. Fitzpatrick

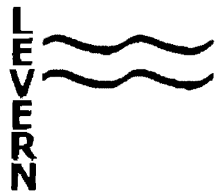
Wesley Phillips (0502823496)
48 Braeside Drive, Barrhead G78 2QB

I saw Wesley for an outpatient review on 07.05.2009. I note that Wesley has recently been in Leverndale with symptoms of low mood, suicidal ideation and complaints of auditory hallucinations or pseudo hallucinations. Whilst in hospital his Chlorpromazine was changed to Quetapine. No definitive diagnosis has been made. Since release, Wesley has continued to use illicit drugs, taking probably quite large amounts of Benzodiazepines and continuing to use Heroin. He has been keeping company with other drug users leading a rather abnormal lifestyle, staying in bed all day and using drugs all night. He complained today of feeling anxious and wanted me to give his Valium, which I declined. I have reinforced to him that his drug and his lifestyle will be having a major impact on his well being at the moment. I have agreed to increase his Methadone to 60 mls. daily and will continue to see him at the clinic.

Yours sincerely

Dr. Charles McMahon
Consultant Psychiatrist

c.c. Dr. Mathias, Leverndale Hospital
Elaine McEwan, St. Andrews House



848 9776

Levern Medical Group

Duty. Agnes

Barrhead Health Centre

201 Main Street

Barrhead G78 1SA

Tel: 0141 314 0801

Fax: 0141 314 0839



RCGP Scotland



23/3/09

Wesley Milligan
5/2/82

Dear Dr. McMahon,

I just gave this chap diazepam 5mg x (20) for agitation as he starts back on methadone. This was on the basis he'll be seeing you this week. I only got your letter (ironically) this later.

I have recorded in the notes that all psychotropic is to be via your clinic until further notice.

Yours sincerely,

COMMUNICATION WITH G.P. FOLLOWING EMERGENCY ASSESSMENT

PATIENT INFORMATION (please complete or affix label to all three copies of form)

Surname PHILLIPS

Forename WESLEY

Maiden name

D.O.B. 5/2/82 Sex M/F

Address 39 SUNNYSIDE PLACE

Unit No. 3496

BARRHEAD

Post Code 978 2RT

Current Contact with Renfrewshire Psychiatric Service Y/N - if yes. Consultant McMAHON Copy Sent

SOURCE OF REFERRAL - G.P./SW/CPN/Self/Police/Other A+E Letter/Phone call

G.P. AHMED

Practice No. 87165

201 MAIN ST, BARRHEAD

(to be completed by Med. Rec)

REASON FOR REFERRAL

suicidal ideation

HISTORY

assessed yesterday night with suicidal ideation + anxiety but had no intent to harm himself so was discharged on chlorpromazine, returned tonight via A+E clo ↑ suicidal thoughts, has a rope at home + planned to hang self. in the woods but decided to seek help instead. Stopped using heroin 2 weeks ago - now on methadone.

MENTAL STATE

casually dressed, appears physically well, mood & low no FTD, vague thoughts that he will be killed if he doesn't kill himself, suicidal intent, auditory pseudohallucinations.

PROVISIONAL DIAGNOSIS

1. depressive episode F32.9
2. polysubstance misuse F19.1

PROPOSED MANAGEMENT/EMERGENCY MEDICATION GIVEN

admitted

DISPOSAL (please tick)

☒ In Patient
Alcohol Problems Clinic
Other (specify)

Social Work
CPN

Out Patient Appointment
GP Care only

Duty Doctor's Signature

M. Hepburn

Time

20⁰⁰

Dr HEPBURN

DATE

5/4/09

Greater Glasgow & Clyde Health Board

Clyde Division

Adult Mental Health

REFERRAL ASSESSMENT (Short Version)

Date Assessed	050409	Time of Assessment (24 Hour)	1910
Surname	PHILLIPS	G.P. Name	DR FITZPATRICK
Forename & Initial	WESLEY	G.P. Address (No. & Street)	LEVERN MED. GROUP BARRHEAD H.C.
Date of Birth	050282	Town	BARRHEAD
Address (No. & Street)	39 SUNNYSIDE PLACE	'Phone No.	01413140801
Town	BARRHEAD	Employment Status	UNEMPLOYED
Post Code	G78 2RT	Referred By:	A+E RAM
'Phone No.		Interviewers Names	1. MHAIRI NEGBVEN 2.
Social Contact		Admitted Hosp. & Ward	
		Not Admitted	

History of Presenting Illness

Emergency assessment at Dykebar last night after presenting to A+E RAM c/o suicidal ideation, anxiety + auditory hallucinations. When seen yesterday had no ongoing suicidal ideation and so was discharged home on chlorpromazine.

Re-referred by A+E today - presented this afternoon c/o P.T. suicidal thoughts.

At iv said he has been lower in mood for past week, only sleeping 1-2 hrs/night, poor appetite, no enjoyment of activities. Usually sleeps + eats well + enjoys going to friends' houses which he spends most of his time doing.

Has a rope at home and has spent most of today thinking about going into the woods and hanging himself, thinks he would do this if he keeps on feeling like this. c/o anxiety, feels as if someone will kill him if he doesn't kill himself but can't say who, why or how - "just a feeling." c/o stiffness in neck for past week - no worsening since being given chlorpromazine yesterday.

Had attended A+E hoping to be admitted here as he doesn't feel he is safe due to his suicidal ideation and wants help.

full hx documented yesterday.

ALLERGIES: none

DRIVING:

Modified Sainsbury's Risk Assessment Done:-

Past Psychiatric History

Attends RDS - sees Dr McMahon
sees drugs worker at St Andrews house
prior admissions to RAM, Stobhill + Greerock with drug
induced psychosis.

Mental State Examination

Appearance & Behaviour very tall man in his 20s, average weight, casually dressed in sportswear, anxious, polite + appropriate, good rapport + eye contact

Affect: Objective & Subjective obj generally appeared euthymic, on verge of tears at one point, not smiling much, looks tense
subj very low

Speech @ in rate, tone + volume, spontaneous

Thought

Form no FTD

Content vague thoughts/feelings that someone will kill him or things will otherwise go very wrong if he doesn't kill himself first, no delusional quality to this. Suicidal intent due to these thoughts.

Perceptual Abnormalities

Pseudohallucinations - hearing voices inside his head telling him to kill himself

Cognitive Function appears intact

Intelligence ~ average

Insight aware he is unwell and needs admission, aware of effect of his drug use on his mental state.

Summary

Collaborative Information *previous assessment from yesterday*

Differential Diagnosis *depressive episode
polysubstance misuse*

Focus of Patient Care

- admit
- physical ✓
- bloods + ECG tomorrow
- check methadone dose tomorrow

Discussed with:-

Admitted To Ward:-

TIME: (24 Hr Clock)

PATIENT ADVISED THAT SMOKING NOT ALLOWED: ☐ YES. ☐ NO.

Not Admitted ☐

Signatures of Assessors

¹ *M. Flynn*

²

Mental Health & Learning Disabilities

Source: Sainsbury Centre for Mental Health

RISK ASSESSMENT AND MANAGEMENT (LEVEL 1)

CLIENT NAME: WESLEY PHILLIPS D.O.B.: 1 / 1 ID No:

ADDRESS: 39 SUNNYSIDE PLACE, BARNHEAD POSTCODE: G78 2RT

DATE/PERIOD OF ASSESSMENT: 5/4/19 TIME: 20:00 REVIEW DATE: 1 / 1

RISK FROM OTHERS (eg. Abuse, exploitation) Details of identified risk:	YES / NO	UNKNOWN Further investigation required*
RISK TO SELF (eg. Suicide, self harm) Details of identified risk: <i>planned to hang self in woods, had rope says wouldn't harm self in hospital</i>	YES / NO	UNKNOWN Further investigation required*
RISK TO OTHERS (eg. Aggression, violence) Details of identified risk: <i>previously aggressive when in hospital, conviction for violent crime, no signs of aggression today</i>	YES / NO	UNKNOWN Further investigation required*
RISK OF NEGLECT (eg. Health, personal) Details of identified risk:	YES / NO	UNKNOWN Further investigation required*
RISK TO CHILD(REN) (eg. Neglect, abuse) Details of identified risk:	YES / NO	UNKNOWN Further investigation required*
RISK OF PHYSICAL IMPAIRMENT (eg. Medical, sensory) Details of identified risk:	YES / NO	UNKNOWN Further investigation required*
RISK OF WANDERING and/or FALLS Details of identified risk:	YES / NO	UNKNOWN Further investigation required*
MEMORY & COGNITIVE IMPAIRMENT (eg. Forgetfulness) Details of identified risk:	YES / NO	UNKNOWN Further investigation required*
CHALLENGES TO SERVICES (eg. Inappropriate demands, poor service response) Details of identified risk:	YES / NO	UNKNOWN Further investigation required*

* Any further investigation required should be part of level 1 Risk Management Plan.

SIGNIFICANT KNOWN HISTORY (including known diagnoses):

known to RDS - prev heroin + cocaine misuse - stopped
2 weeks ago + is on methadone
3 prev admissions with drug induced psychosis

INITIAL ASSESSMENT OF RISK (including context, situations in which risks may occur):

at risk of harming self if allowed home due to
suicidal ideation
further information needed re previous violence and
its context

INITIAL RISK MANAGEMENT PLAN (including who is to do what):

admit to hospital

SOURCES OF INFORMATION : AVAILABLE

previous assessment - from yesterday

CONTEXT OF CLIENT FOR ASSESSMENT

emergency assessment by duty dr

ROLE OF CLIENT and/or CARER IN PLAN:

CLIENT INVOLVED: YES / NO

CARER INVOLVED: YES / NO

CLIENT AGREED: YES / NO

CARER AGREED: YES / NO

COMMENTS:

NEED FOR RISK ASSESSMENT & MANAGEMENT (LEVEL 2) YES / NO

Recorded by: *M. H. [signature]* Date: 5/4/09

Discussed with: Time: 20⁰⁰

NAME

CLINICAL NOTES CONT'D

UNIT NUMBER

DATE

Receiving Psychiatrist.
574/5.

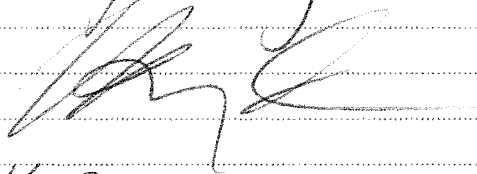
Dear Doctor

Re: Wesley Phillips
512/82.

Many thanks for seeing this
27 yr old man who has
re-presented with suicidal
ideation.

I enclose his A+E card.

Faithfully -



L. HYDE

A+E STAFF GRADE.

Inpatient and Emergency Department
Royal Alexandra Hospital, Corsebar Road,

6WA



0502823496



A&E No.09022292

3

Surname	PHILLIPS	First Name	WESLEY	Title:
Address:	39 SUNNYSIDE PLACE	Postcode	G78 2RT	
	BARRHEAD	Telephone:		
	GLASGOW			
Date of Birth:	05.02.82	Sex:	M	Age: 27 yrs

GP Name:	AHMEED		
Address:	Barrhead Health Centre	Postcode	G78 1SA
	201 Main Street	Telephone:	0141 314 0801
	Barrhead		

Next of Kin	
Relationship:	
Address:	Postcode
	Telephone:
Primary Carer:	

Date of Attendance: 5/11/09 17:00

Date of Incident:

Presenting Complaint: SUICIDAL

Triage	MODERATE	OF SELF HARM? SEE MEWS CHART	Tetanus Cover:
			Allergies:
P=	BP=	RR=	Sat=
PF=	GCS=	V: Total:	BM=

Drugs Prescribed						
Date	Dr	Dose	Route	Signature	Given By	Time

CHILD ASSESSMENT QUESTIONNAIRE: Complete for all children under 16

	YES	NO
Previous attendance (consultations) relevant trauma from previous presentations)		
History variable between assessment and history/presentation		
Examination not compatible with history/presentation		
Delay in presentation		
Fracture/head injury or significant bruising in baby or non-mobile toddler		
Discussed with Senior Medical Staff/Nurse on duty any factors identified		

DRUG PRESCRIPTIONS.

In Dependent & On discharge (Identify frequency for discharge drugs)

Date Given	Drug (Block capital)	Dose	Frequency	Route Given	Time Given	Signature	Given by

Seen By LH91

Consultant Alister

Date/Time	
5/4/9	(27) Suicidal - getting worse
	Presented last night + seen at Dykebar Magistrate and allowed home. No F/U plans that patient is aware of.
	Feeling worse today. Thinking about suicidal all the time, has rope and has thought about going to woods behind Barrhead.
	Taken ODS and self harm cutting to arm before.
	<u>SUPPORT</u>
	St Andrews house, Barrhead. - Fine workers. Sees every 2-3 wks.
	She lives alone. Smokes a couple/day. Non-smoker stopped 5-6 yrs ago.

Body Part Stamp

Date

heroin until few wks ago.
on methadone just now.

Dts

Methadone 50mg.

Largactil 25mg qds. - started last night
(was on one daily before that)

Plan

D/W on-call psychiatrist
transfer + for admission.

[Signature]

Discharge Codes (please circle)

- 1. Discharge Home
- 5. Other Clinic

Refer GP
transfer

- 3. A&E Clinic
- 7. Admit Ward

- 4. Fracture Clinic
- 8. Patient Deceased

COMMUNICATION WITH G.P. FOLLOWING EMERGENCY ASSESSMENT

PATIENT INFORMATION (please complete or affix label to all three copies of form)

Surname PHILLIPS

Forename WESLEY

Maiden name

D.O.B. 5.2.82 Sex M/F

Address 39 SUNNYSIDE PLACE

Unit No. 3496

BARRHEAD

Post Code G78 2RT

Current Contact with Renfrewshire Psychiatric Service Y/N - if yes. Consultant MS MASON Copy Sent

SOURCE OF REFERRAL - G.P./SW/CPN/Self/Police/Other AIC RAH Letter/Phone call

G.P. DR AHMED / DR FITZPATRICK
BARRHEAD, 201 MAIN ST

Practice No. 87165

(to be completed by Med.Rec)

REASON FOR REFERRAL

Anxiety, suicidal ideation

HISTORY

Recently stopped multiple recreational drugs & commenced on methadone.

Anxiety state w/ vague suicidal ideation

MENTAL STATE

Calm, friendly. Euthymic. Vague
paranoia. Not suicidal.

PROVISIONAL DIAGNOSIS

- Anxiety state F41.9
- Drug withdrawal F19.3

PROPOSED MANAGEMENT/EMERGENCY MEDICATION GIVEN

Give chlorazepate 25mg qds.
RDS to be contacted.

DISPOSAL (please tick)

In Patient

Social Work

Out Patient Appointment

Alcohol Problems Clinic

CPN

GP Care only

Other (specify)

Home.

Duty Doctor's Signature

Clm Hennessey

Time

2300

DR HENNESSY

DATE

4.8.09

Greater Glasgow & Clyde Health Board

Clyde Division

Adult Mental Health

REFERRAL ASSESSMENT

Date Assessed	04/04/09	Time of Assessment (24 Hour)	21:55
Surname	PHILLIPS	G.P. Name	DR FITZPATRICK
Forename & Initial	WESLEY	G.P. Address (No. & Street)	LEVERN MEDICAL GROUP BARRHEAD H.C.
Date of Birth	05/02/82	Town	BARRHEAD
Address (No. & Street)	39 SUNNYSIDE PLACE	'Phone No.	
Town	BARRHEAD	Employment Status	UNEMPLOYED
Post Code	G78 2RT	Referred By:	A+E RATH
'Phone No		Interviewers Names	1. C. HENNESSY 2. J. MITCHELL
Social Contact		Admitted Hosp. & Ward	
		Not Admitted	Not admitted.

History of Presenting Illness

PC: ALE offered
successful admission

HPC: Presented this to ALE w/ "para attack" -
felt he was going to die. Also had
thoughts of hurting self/ taking OD. No plans
to suicidal acts. Did not want to be
dead. Has many positive factors & hopes
for future.

P. felt anxious for ~ 2/52. Feb mnd is
high. Cal. Good. Experiencing CP, SOB. Cal
sleep. Appetite poor. Mood low. Little
motivation.

Parahallucinations - voice saying "kill yourself";
shadows in his vision.

Stopped heroin 3/52 ago. Stopped back on methadone
(50mg). Stopped all drugs (heroin, coke, etc)
recently too.

New girlfriend (involved in Christian rehab)

requesting help re: anxiety.

ALLERGIES:**DRIVING:****Modified Sainsbury's Risk Assessment Done:-** ✓**Past Psychiatric History**

known to Dr Dr Melton, R.D.S.
 Drugs work: Alizer, Hetero, St Johns Road
 3 prior admissions - Green, St John, R.H.
 Previous drug-induced psychosis

Past Medical History

NFI

Current & Past Medication and ALLERGIES

Name	Dose	Frequency	Current/Not Current	Other Information
Largactil Medication	50ml			

ALLERGIES

NFI

Family History

Mother	Died 2 years ago.
Father	In hospital.
Siblings	2 brothers. 1 is in hospital. } In contact.
Children	NFI.

Personal History

Birth/Childhood	From Port Glasgow (born in Glasgow - dad is army) lived together. Divorced when he was 20. Good childhood.
School/Education	Always suspended. Kicked out of 15 & attended home care (special school).

Illicit Drug usage & Alcohol History

Heroin until I went to prison

Prison cocaine, heroin, "everything" Really stopped all.

C.A.G.E. Questionnaire

Units of Alcohol per week

Forensic History

Prison until 2/9/08 - 16 months. Armed robbery
5 other prison sentences - carrying weapon, BOP, police
assault
no outbursts

Effect of Presenting Problem on Daily Living

Effect of Presenting Problem on Relationships with Others

Mental State Examination

Appearance & Behaviour

Well presented. Relaxed, friendly. Easy rapport & CC

Affect: Objective & Subjective

"low"

Obj: Euthymic, controlled

Speech

Normal

Thought

Form

OFTD

Content

No suicidality. Reptal.

Perceptual Abnormalities

Perceptual hallucinations (visual & audio)

Cognitive Function

Oriented to T/P/P

Intelligence

Not assessed

Insight

Good.

Summary

27 ♂ recently stopped all recreational drugs.

No escalating anxiety w/ vague suicidal ideation.

Collaborative Information

NI

Differential Diagnosis

anxiety disorder

Focus of Patient Care

- 1) Chlorpromazine 25mg qd
- 2) Sertraline
- 3) CBB numbers
- 4) Alben Patel to be contacted more.

Discussed with:-

Dr. Aher, SPR

Admitted To Ward:-

NI

TIME: (24 Hr Clock) ~~2300~~ 2300

Not Admitted

Signatures of Assessors

¹ Colm Henry

² Jane Nuttall

Mental Health & Learning Disabilities

Source: Sainsbury Centre for Mental Health

RISK ASSESSMENT AND MANAGEMENT (LEVEL 1)

CLIENT NAME: Wesley Phillips D.O.B.: 5 / 2 / 1982 ID No:

ADDRESS: 39 Sunnyside Place BARRHEAD POSTCODE: G78 2RT

DATE/PERIOD OF ASSESSMENT: 4 / 4 / 09 TIME: 21.55 REVIEW DATE: 1 / 1

RISK FROM OTHERS (eg. Abuse, exploitation)

Details of identified risk:

YES / NO

UNKNOWN

Further investigation required*

RISK TO SELF (eg. Suicide, self harm)

Details of identified risk: History of DSH. Says previous suicide attempt. Done DSH for 2 years. Recent thoughts of overdose or hanging - has not acted on these + has sought help. Does not want to act on thoughts.

YES / NO

UNKNOWN

Further investigation required*

RISK TO OTHERS (eg. Aggression, violence)

Details of identified risk: History of violence. Served 14 months for armed robbery - released Sept '08

YES / NO

UNKNOWN

Further investigation required*

RISK OF NEGLECT (eg. Health, personal)

Details of identified risk:

YES / NO

UNKNOWN

Further investigation required*

RISK TO CHILD(REN) (eg. Neglect, abuse)

Details of identified risk:

YES / NO

UNKNOWN

Further investigation required*

RISK OF PHYSICAL IMPAIRMENT (eg. Medical, sensory)

Details of identified risk:

YES / NO

UNKNOWN

Further investigation required*

RISK OF WANDERING and/or FALLS

Details of identified risk:

YES / NO

UNKNOWN

Further investigation required*

MEMORY & COGNITIVE IMPAIRMENT

(eg. Forgetfulness)

Details of identified risk:

YES / NO

UNKNOWN

Further investigation required*

CHALLENGES TO SERVICES

(eg. Inappropriate demands, poor service response)

Details of identified risk: Previously threatened violence to those trying to deliver care. Poor engagement with services other than when in crisis

YES / NO

UNKNOWN

Further investigation required*

* Any further investigation required should be part of level 1 Risk Management Plan.

SIGNIFICANT KNOWN HISTORY (including known diagnoses):

Previous diagnoses: Emotionally Unstable Personality Disorder + Poly-substance abuse
Known to RDS: Previous contact with services in Inverclyde
Started Methadone 3/52 ago. Says no drugs for 1/52. Feels like taking his own or
killing himself because of anxiety + tightness in his neck. Feeling
anxious for 2/52. Wanted help + attended A+E RHH today.

INITIAL ASSESSMENT OF RISK (including context, situations in which risks may

occur):

"If I got help I wouldn't want to be dead. I just want
to get help." No immediate risk identified at interview.
Admits he has a lot to live for + feels his life continues
to improve as he is dealing with his drug problem.

INITIAL RISK MANAGEMENT PLAN (including who is to do what):

Dr Mc Mahon / Alison Fletcher to be asked for urgent review
Given 6x Chlorpromazine 25mg tabs. (1 to be taken 4 times daily)
and immediate prescription change form to take to GP on Monday.
Given info re FIRST. Says he has info on Breasting Space.

SOURCES OF INFORMATION : AVAILABLE

Letters from K Davis

CONTEXT OF CLIENT FOR ASSESSMENT

Referred by A+E RHH for assessment due to
suicidal ideas.

ROLE OF CLIENT and/or CARER IN PLAN:

CLIENT INVOLVED: YES / NO

CARER INVOLVED: YES / NO

CLIENT AGREED: YES / NO

CARER AGREED: YES / NO N/A

COMMENTS:

NEED FOR RISK ASSESSMENT & MANAGEMENT (LEVEL 2) YES / NO

Recorded by: Julie Mitchell

Date: 4.4.09

Discussed with: Ann Harvey

Time: 22.45

MENTAL HEALTH DIRECTORATE
(RENFREW)
DYKEBAR HOSPITAL
GRAHAMSTON ROAD
PAISLEY PA2 7DE
TELEPHONE: 0141 884 5122
FAX: 0141 884 7162



If TELEPHONING, PLEASE ASK FOR

DATE: 4/4/09 22:00

Dear Dr: FITZPATRICK

Re: WESLEY PHILLIPS, DOB 5/2/82

I saw your patient at the out patient clinic on Dykebar Acute Admissions Unit.

I would be grateful if you could prescribe the following medication:

Acute referral from A&E - suicidal ideation,
anxiety.
Supplied ✓ 6 x 25mg chlorpromazine (QDS)
Please continue until seen by RDS.

A letter containing further details will follow.

Yours sincerely

Colin Hemmery, ST1 Y on-call

COMMUNICATION WITH G.P. FOLLOWING EMERGENCY ASSESSMENT

Con

PATIENT INFORMATION (please complete or affix label to all three copies of form)

Surname PHILLIPS

Forename WESLEY

Maiden name _____

D.O.B. 5/2/82 Sex M/F

Address 39 SUNNYSIDE PLACE

Unit No. 3496

BARRHEAD

Post Code 978 2RT

Current Contact with Renfrewshire Psychiatric Service Y/N - if yes, Consultant McMATION Copy Sent

SOURCE OF REFERRAL - G.P./SW/CPN/Self/Police/Other A+E Letter/Phone call

G.P. ARMED

Practice No. 87165

201 MAIN ST, BARRHEAD

(to be completed by Med Rec)

REASON FOR REFERRAL

suicidal ideation

HISTORY

assessed yesterday night with suicidal ideation + anxiety but had no intent to harm himself so was discharged on chlorpromazine, returned tonight via A+E c/o suicidal thoughts, has a rope at home + planned to hang self in the woods but decided to seek help instead. Stopped using heroin 2 weeks ago - now on methadone.

MENTAL STATE

casually dressed, appears physically well, mood low no FTD, vague thoughts that he will be killed if he doesn't kill himself, suicidal intent, auditory pseudohallucinations.

PROVISIONAL DIAGNOSIS

1. depressive episode F32.9
2. polysubstance misuse F19.1

PROPOSED MANAGEMENT/EMERGENCY MEDICATION GIVEN

admitted

DISPOSAL (please tick)

☒ In Patient
Alcohol Problems Clinic
Other (specify) _____

Social Work
CPN

Out Patient Appointment
GP Care only

Duty Doctor's Signature M. Hepburn Time 20⁰⁰

Dr Hepburn

DATE 5/4/09

COMMUNICATION WITH G.P. FOLLOWING EMERGENCY ASSESSMENT

PATIENT INFORMATION (please complete or affix label to all three copies of form)

Surname PHILLIPS

Forename WESLEY

Maiden name

D.O.B. 5.2.82 Sex M/F

Address 39 SUNNYSIDE PLACE

Unit No. 3496

BARRHEAD

Post Code G78 2RT

Current Contact with Renfrewshire Psychiatric Service Y/N - if yes. Consultant MEMORANDUM Copy Sent

SOURCE OF REFERRAL - G.P./SW/CPN/Self/Police/Other A+E RAH Letter/Phone call

G.P. DR AHMED / DR FITZPATRICK
BARRHEAD, 201 MAIN ST

Practice No. 87165

(to be completed by Med.Rec)

REASON FOR REFERRAL

Anxiety, suicidal ideation

HISTORY

Recently stopped multiple recreational drugs & commenced on methadone.

Anxiety state w/ vague suicidal ideation

MENTAL STATE

Calm, friendly. Euthymic. Vague periphrastics. Not suicidal.

PROVISIONAL DIAGNOSIS

1. Anxiety state F41.9
2. Drug withdrawal F15.3

PROPOSED MANAGEMENT/EMERGENCY MEDICATION GIVEN

Given clonazepam 25mg qds
RDS to be continued.

DISPOSAL (please tick)

In Patient

Social Work

Out Patient Appointment

Alcohol Problems Clinic

CPN

GP Care only

Other (specify) Home

Duty Doctor's Signature

Colm Hennessey

Time

2300

DR HENNESSEY

DATE

4/8/09

10 St. James Street
PAISLEY PA3 2HT

Our ref. CMCM/DC/CHI

Renfrewshire Drug Service
Direct - 0141-889-1223
Fax: 0141-848 9776

Date: 20th April 2009

Dictated: 9th April 2009

Typed: 20th April 2009

PRIVATE & CONFIDENTIAL

Mr. Wesley Phillips
48 Braeside Drive
Barrhead G78 2QB

Dear Wesley

I am very disappointed you did not attend your appointment with me on 09.04.2009. Can I take this opportunity of reminding you that you must attend all your appointments to allow us to monitor your progress in treatment. A further appointment will be arranged in the near future, which you must attend.

Yours sincerely

Dr. Charles McMahon
Consultant Psychiatrist

c.c. Alison Fletcher, St. Andrews House

10 St. James Street
PAISLEY PA3 2HT

Our ref. CMCM/DC/CHI 050282
3496

Renfrewshire Drug Service

Direct - 0141-889-1223
Fax: 0141-848 9776

Date: 31st March 2009

Date Dictated: 26th March 2009
Date Typed: 31st March 2009

PRIVATE & CONFIDENTIAL

Dr. Fitzpatrick
The Levern Medical Group
Barrhead Health Centre
201 Main Street
BARRHEAD G78 1SA

Dear Dr. Fitzpatrick

Wesley Phillips (0502823496)
48 Braeside Drive, Barrhead G78 2QB

I saw Wesley back for review at the Drug Clinic on 26.03.2009. He seems to have managed reasonably well in the first couple of weeks on a prescription. He claims to have reduced his Heroin use right down, but of course there remains a question about the reliability of any of Wesley's history. Thank you for letting me know about his presentation with anxiety and getting a small amount of Diazepam. I have reinforced to him today that psychotropic prescribing would be done via the clinic. I have given him a small dose of Chlorpromazine along with his Methadone on a daily pick-up from the chemist and will see him again in another couple of weeks.

Yours sincerely

Dr. Charles McMahon
Consultant Psychiatrist

c.c. Alison Fletcher, St. Andrews House

Phillips, Wesley, CHI: 0502823496, 23-Feb-2009, East Renfrewshire CAT Team

Page 1 of 3



file
✓

Hospital use only	Clinic	Day Date	Time	Hospital No.
-------------------	--------	----------	------	--------------

Transport required?

REFERRAL LETTER

MEDICAL IN CONFIDENCE

REFERRAL TO

East Renfrewshire CAT Team G126
G Mental Health

CAT (Community Addiction Team)

— Consultant / receiving practitioner and/or specialty clinic

— Hospital and hospital address

Hospital location code.

G004G

Email address

-

Urgency of referral

URGENT

Date of referral

23-Feb-2009

Date sent

24-Feb-2009

PATIENT DETAILS

Surname	Phillips
Forename(s)	Wesley
Title	Mr
Sex	Male
Date of birth	05-Feb-1982
CHI no.	0502823496

Patient's address

48 Braeside Drive
BARRHEAD
Glasgow
EAST RENFREWSHIRE
G78 2QB

Contact number(s)

Voice: 580 0223
Voice: 07865157213

REGISTERED GP DETAILS

Name	Dr Jennifer May		
GMC code	4092401	GP code	C39128
Practice name	Levern Medical Group		
Practice code	87165		

Practice address

Levern Medical Group, Barrhead Health Centre
201 Main Street
Barrhead
G78 1SA

Contact number(s)

Voice: 0141 314 0801
Facsimile: 0141 314 0839

REFERRING GP DETAILS

Name	Dr. James Fitzpatrick		
GMC code	3254118	GP code	37605
Practice name	Barrhead Health Centre (87165)		
Practice code	87165		

Practice address

201 Main Street
Barrhead

Contact number(s)

Voice: 0141 314 0801

Phillips, Wesley, CHI: 0502823496, 23-Feb-2009, East Renfrewshire CAT Team

Page 2 of 3

848 9770

CLINICAL INFORMATION**History of presenting complaint / examination findings / investigation results****Presenting complaint**

Description: Psychotic disorder. Heroin misuse

Comment: Dear dr McMahon

Thank you for agreeing to see this gentleman on the 12th March. It might be useful for you to peruse his old notes by and large from the Greenock area which show long history of disturbed childhood and psychiatric interventions with possible diagnosis of Tourette's syndrome being made. He joined our practice a few months ago having been discharged from Greenock Prison and had been closely involved with some church in the Greenock area. I believe an individual related to this is trying to organise a residential rehab place for him in Red Towers in Helensburgh.

He had been reasonably stable on Venlafaxine for anxiety and panic but reported recently that he had lapsed into heroin usage again and criminal activity in addition. He hears voices urging him to commit crime in order to fund the drug habit and I believe these are genuine hallucinations as opposed to merely opiate dependence. I am reviewing him this week having given him a low dose of Chlorpromazine over the weekend.

His extensive forensic and psychiatric history I am sure you would agree would merit some expert input. Thanks for seeing him.

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Ex smoker:		17-Sep-2008
Stopped drinking alcohol:		17-Sep-2008
Enjoys moderate exercise:		17-Sep-2008

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history**Past procedures** (High and medium priority - all)

Description	Modifier	Date performed
Hepatitis C PCR	-	01-Aug-2008

Family conditions (All priorities)

Description	Modifier	Extension	Date Recorded
No FH: Ischaemic heart disease	-	-	27-Oct-2008
FH: Diabetes mellitus	-	-	27-Oct-2008

Current medication (Active Repeat medication issued within the last 12 months)

No current medications recorded.

Recent medication (Any medication issued within last 90 days not shown above)

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued	Duration
Chlorpromazine Hydrochloride	21	TABS 25MG	1 Tab	3 times daily	17-Feb-2009	-	0 Days
Venlafaxine Mr	28	CAPS 150MG	1 Cap	Daily	30-Jan-2009	-	0 Days
Venlafaxine Mr	28	CAPS 150MG	1 Cap	Daily	29-Dec-2008	-	0 Days
Venlafaxine Mr	56	CAPS 75MG	1 Cap	Daily	10-Nov-2008	-	0 Days
Oxytetracycline	56	TABS 250MG	1 Tab	Twice daily	14-Oct-2008	-	0 Days
Venlafaxine Mr	28	CAPS 75MG	1 Cap	Daily	14-Oct-2008	-	0 Days

Phillips, Wesley, CHI: 0502823496, 23-Feb-2009, East Renfrewshire CAT Team

Page 3 of 3

Venlafaxine Mr	14	CAPS 75MG	1 Cap	Daily	30-Sep-2008	-	0 Days
Mirtazapine	14	TABS 30MG	1 Tab	At night	15-Sep-2008	-	0 Days

Clinical warnings

Additional relevant information**Administrative Information**

OK to send correspondence to home address?:Yes
Patient will accept any site:Yes
Patient will accept cancellation or short notice appointment (within 1-21 days):Yes
Patient has disability or requires wheelchair access:No
Referred By:Referring GP
Electronic Attachment Present:No

Signature of referring doctor (or other professional) Date

10 St. James Street
PAISLEY PA3 2HT

Our ref. CMCM/DC/CHI 050282
3496

Renfrewshire Drug Service

Direct - 0141-889-1223
Fax: 0141-848 9776

Date: 13th March 2009

Date Dictated: 12th March 2009
Date Typed: 13th March 2009

PRIVATE & CONFIDENTIAL

Dr. Fitzpatrick
The Levern Medical Group
Barrhead Health Centre
201 Main Street
BARRHEAD G78 1SA

Dear Dr. Fitzpatrick

Wesley Phillips (0502823496)
48 Braeside Drive, Barrhead G78 2QB

I saw this man at the Drug Clinic on 12.03.2009. I had a chance to look at the records in the practice and I note his previous history and extensive contact with mental health services, primarily in Inverclyde. This man has presented significant challenges in the past. There is a history of poor engagement and poor co-operation with services and acts of violence and threats of violence towards those trying to deliver care. In addition there is a significant forensic history, including offences involving the use of weapons. His psychiatric diagnosis has always been one of emotionally unstable personality disorder and there has been a persistent pattern of presenting to services in crisis, but subsequently not engaging in a constructive manner. There is also a long-standing history of substance misuse, which has obviously complicated his presentation and added to the difficulties in management.

It would appear he was treated by his GP, Dr. Mutch in Port Glasgow, with Methadone for while in 2007. He said that his Mum died about then and he went to Wales and got Methadone there and then said he went to London and came off Methadone. He said he said he came back home and robbed a shop in Greenock and served a prison sentence where he became drug free. He said he got out of prison in 2008 and was housed in East Renfrewshire. His account and indeed that confirmed by housing is that he appeared to manage reasonably well for the first several months, but things have deteriorated dramatically since then. He reports engaging in chaotic polysubstance misuse. He gave a not particularly consistent comprehensive account of his drug use today, claiming to be using large amounts of Cocaine, Benzodiazepines, Heroin, Subutex and Methadone. He looked actually quite presentable today, quite coherent and quite pleasant. He claimed he had taken £90 worth of rock Cocaine and three bags of Heroin, but his appearance was not consistent with that.

A couple of urine samples we have taken have been positive for Benzodiazepines. One has been positive for Opiates and one for Subutex and both also positive for Cocaine.

Cont'd/... ..

In terms of his mental health he was calm, reasonable and appropriate today. He told me that he suffered from a drug induced psychosis, telling me that the symptoms of that were taking up in the night feeling that his dreams might be real and he would therefore need someone to be with him and he also said he became agitated at times.

He said that he got prescriptions of Chlorpromazine, Venlafaxine and Zopiclone recently from various doctors in the practice. He claimed he took them immediately to try and relieve his withdrawal symptoms and they have all run out.

At the present time he is very keen on getting onto Methadone, saying that he is confident he can reduce his drug use. He did have some idea of moving to a rehab in England or Wales, but it seems that they have decided not to admit him. I have obviously counselled him that he needs to be looking at Methadone as a long-term intervention, which he seems to accept. I have reminded him that we would be unable to tolerate any kind of violent or destructive behaviour whilst he is in treatment with us and again he readily gave me his assurances about that. Given that he has not been injecting recently and his account of his drug use was somewhat inconsistent, I am going to see if he will see Alison Fletcher on Monday morning in withdrawal and then commence on a relatively low dose of Methadone 30 mls. daily to be built up slowly over the coming weeks.

Given his chaotic drug and the account that he has been misusing tablets that have been prescribed to him, it probably would be best to keep any psychotropic prescribing to the clinic so that it can be dispensed on a daily basis along with his Methadone. I am not going to prescribe him at the minute and again he seemed happy with that. I will see him again in the future.

Yours sincerely

Dr. Charles McMahon
Consultant Psychiatrist

c.c. Alison Fletcher, St. Andrews House

COMMUNICATION WITH G.P. FOLLOWING EMERGENCY ASSESSMENT

FILE

PATIENT INFORMATION (please complete or affix label to all three copies of form)

Surname Philips

Forename Wesley

Maiden name

D.O.B. 5/2/82 Sex M/F

Address 45 Prospect Hill

Unit No. 3496

Court

Post Code PA15 4EZ

Greenock

Current Contact with Renfrewshire Psychiatric Service Y/N - if yes, Consultant..... Copy Sent

SOURCE OF REFERRAL - G.P./SW/CPN/Self/Police/Other..... A+E..... Letter/Phone call

G.P. Dr. Mutch

Practice No. 86336

4 Dubbs Place, Port Glasgow

(to be completed by Med. Rec)

REASON FOR REFERRAL

Suicide ideation.

HISTORY

Shoplifted this week. Look for reassurance by church member - instead told he was going to die and go to hell. Since then he has been pre-occupied with this. Feeling suicidal but no attempts or plans. No evidence of depressive illness or psychosis.

MENTAL STATE

Well kept, appropriate behaviour. Mood, Speech, thoughts normal.

PROVISIONAL DIAGNOSIS

1. Personality Disorder F60.9.
2.

PROPOSED MANAGEMENT/EMERGENCY MEDICATION GIVEN

- ① Given encouragement and reassurance.
- ② Talked at length about personality Disorder.
- ③ Patient felt supported and appeared optimistic about religious approach.

DISPOSAL (please tick)

In Patient
Alcohol Problems Clinic
Other (specify)

Social Work
CPN

Out Patient Appointment
GP Care only

Duty Doctor's Signature.....

Time 4.20 am

DATE 24/6/6

**GREATER RENFREWSHIRE DIVISION
Mental Health Directorate
Adult Mental Health**

Date 07 February 2006
Dictated 03 February 2006
CHI No 050282-3496
Your Ref
Our Ref SM/MJD
Direct Line 0141-314-4288

PRIVATE & CONFIDENTIAL

Dr Mutch
4 Dubbs Place
Port Glasgow

Dear Dr Mutch

**RE: WESLEY PHILLIPS - D.O.B. 05.02.1982
48 BRAESIDE DRIVE BARRHEAD G78 2QB (TEMPORARY ADDRESS)**

Date of Admission: 29.01.2006
Date of Discharge: 30.01.2006

Type of Discharge:	Planned Discharge	☒
	Early Discharge at Patient Request	☐
	AMA	☐
	LOA (liable to detention S.18 MHA)	☐

Discharge Diagnosis: (ICD10) Emotionally unstable personality disorder

Medication: None given

Management Plan on Discharge: Referred back to GP and local services, as appropriate

I am sure you know this man very well. I understand that he has been a patient at Inverclyde Royal under the care of Dr Deering and Dr Loudon over the last seven years and having discussed his case with Dr Loudon on the 30 January 2006, I understand that while attendance at the Day Hospital was offered to the patient, he was discharged from the service after he caused criminal damage to the Unit. I understand from the patient that through his criminal charges he has been offered an anger management course at some point soon.

He made his way to Accident and Emergency at the Royal Alexandra Hospital because, after he cut his wrists on 28 January 2006, his mother had asked him to leave the house. He arrived at Accident and Emergency to say that he was suicidal and he was referred to Dykebar Hospital for assessment by the SHO there. A bed was found in Inverclyde Royal Hospital and transfer was being arranged but was halted when the patient details were given to staff at Inverclyde Royal because apparently the patient is no longer permitted admission to the psychiatric department. He was therefore transferred to Ward 2 of the Royal Alexandra Hospital under my care.

**Dykebar Hospital, Grahamston Road, Paisley PA2 7DE
Telephone : 0141-884 5122 Fax: 0141-884 7162**

Throughout the day of the 29 and 30 January 2006, there was no evidence whatsoever of any mental health problems. He admitted to staff and to me that he had felt suicidal for a very long time and that he had frequently hurt himself over the years. He told us that he was diagnosed as suffering from personality difficulties and he admitted that he did "trash" the Day Hospital, which led to his discharge from Inverclyde. He told me that he had subsequently gone to Gartnavel Royal Hospital to seek admission there and had been an in-patient there for some time. He denied any symptoms suggestive of affective illness and I was able to confirm that, in my view, he suffered from personality difficulties and that his admission had been prompted by an argument at home.

Having discussed his case with Dr Loudon, I felt that it would be unhelpful for the patient to remain an in-patient for any length of time. I discussed this with him and he was quite willing to take discharge that evening.

No arrangements have been made for follow-up but I am sending a copy of this to Dr Loudon and Dr Deering at Inverclyde Royal Hospital for their information.

I should add that I received a telephone call the following morning from the Community Psychiatric Nurse, who offers a Court Liaison Service to Paisley Sheriff Court. He told me that the patient had telephoned the Police later on on the evening of discharge to inform them that he had a knife and intended to harm either himself or someone else. He was detained overnight in Police custody.

Kind regards.

Yours sincerely

Dr Helen M Anderson
Consultant Psychiatrist

cc **Dr J Loudon, Consultant Psychiatrist, Inverclyde Royal Hospital**
 Dr A Deering, Consultant Psychiatrist, Inverclyde Royal Hospital

COMMUNICATION WITH G.P. FOLLOWING EMERGENCY ASSESSMENT

PATIENT INFORMATION (please complete or affix label to all three copies of form)

Surname Philips

Forename Wesley

Maiden name _____

D.O.B. _____ Sex M/F

Address 45 Prospect Hill Court
GREENOCK

Unit No. _____

Post Code PA15 4ER

Current Contact with Renfrewshire Psychiatric Service Y/N - if yes, Consultant Dr Dearing Copy Sent

SOURCE OF REFERRAL - G.P./SW/CPN/Self/Police/Other Dr Ameen Letter/Phone call

G.P. Dr. Mutch Michael

Practice No. _____

(to be completed by Med. Rec.)

REASON FOR REFERRAL

1) To assess suicidality

HISTORY

3 month w/o low mood

2) Constant suicidal thoughts

3) No recent act
plans to take an overdose

MENTAL STATE

1) Maintained eye contact, 2) Rapport

3) Restricted affect

4) Inappropriate

PROVISIONAL DIAGNOSIS

1. Moderate depressive episode

2. _____

PROPOSED MANAGEMENT/EMERGENCY MEDICATION GIVEN

→ To admit. But Inverclyde hospital staff said initially bed was available. Later they said that no bed was available. Later they refused to take. So admit to ward 2

DISPOSAL (please tick)

☒ In Patient
Alcohol Problems Clinic
Other (specify) _____

☐ Social Work
CPN

☐ Out Patient Appointment
GP Care only

Duty Doctor's Signature _____

Time 3.52 AM

DATE 29/1/06

**Greater Renfrewshire Division
Mental Health Directorate
Adult Mental Health**

Date: 2nd November 2005
Date Dictated: 02.11.05.
Your Ref
Our Ref MAC/KLK/05.02.82. 3496
Direct Line 0141- 314 - 4290

Renfrew/Barrhead Sector
Dr. Martin Culshaw
Dr. J.E. Thomson
Dr. J.S. Luthra - Locum

PRIVATE & CONFIDENTIAL:

Dr. A.F. Nicholson
Barrhead Health Centre
201 Main Street
BARRHEAD
G78 1SD

Dear Dr. Nicholson,

**WESLEY PHILLIPS, C/O 48 BRAESIDE DRIVE, BARRHEAD, G78 2QB. DOB 05.02.82. CHI
NUMBER: 0502823496**

Thank you for your urgent referral on the above named patient. Mr. Phillips was offered an urgent out-patient appointment at Dykebar Hospital on Wednesday 2nd November 2005 at 10.00am. However Mr. Phillips' father contacted my secretary upon receipt of the appointment letter to inform us that Wesley Phillips has now moved back to the Inverclyde area and is living with his mother and has been referred to the appropriate psychiatric services covering the Inverclyde area. I have therefore cancelled his appointment and have discharged him from our service.

Yours sincerely

Dr. Martin Culshaw
Consultant Psychiatrist

**Greater Renfrewshire Division, Mental Health Directorate, Adult Mental Health,
Dykebar Hospital, Grahamston Road, Paisley PA2 7DE
Telephone : 0141-884 5122 Fax: 0141-884 7162**

Greater Renfrewshire Division
Mental Health Directorate
Adult Mental Health

Date: 26th October 2005
Date Dictated: 26.10.05.
Your Ref
Our Ref: MC/KLK/05.02.82. 3496
Direct Line: 0141- 314-4290

Renfrew/Barrhead Sector
Dr. M. Culshaw
Dr. J.E. Thomson
Dr. J.S. Luthra – Locum

PRIVATE & CONFIDENTIAL

Mr. Wesley Phillips
C/O 48 Braeside Drive
BARRHEAD
G78 2QB

Dear Mr. Phillips,

I am writing to offer you an out-patient appointment to attend Dr. Culshaw's clinic at Dykebar Hospital on:

**WEDNESDAY 2ND NOVEMBER 2005 AT 10.00AM AT THE
OUT-PATIENT DEPARTMENT AT DYKEBAR HOSPITAL**

Please telephone 0141 314 4290 to confirm your attendance at this appointment as soon as possible. If you are unable to attend this appointment please telephone the number above to cancel and an alternative appointment will be arranged.

Yours sincerely

Secretary to Dr. M. Culshaw
Consultant Psychiatrist

c.c. Dr. A.F. Nicholson, Barrhead Health Centre, 201 Main Street, BARRHEAD, G78 1SW – For information.

MC

MC

(4)

✓
appt
letter
sent
26/10
th

PARTICULARS OF PATIENT
IN BLOCK LETTERS PLEASE

Hospital use Only	Clinic <u>Dr. M. Wisnaw</u>	Day Date <u>Wed 02-11-05</u>	Time <u>10:00</u>	Hospital No.	GP112
REQUEST FOR OUT-PATIENT CONSULTATION THE INFORMATION IN THIS SECTION MUST BE COMPLETED					Appointment Category Routine ☐ Soon ☐ Urgent ☒
Hospital <u>D-ICEBAR</u>	Date <u>19/10/05</u>	CHI No. <u>050282</u>			
Please arrange for this patient to attend the <u>PSYCHIATRIC</u> clinic of Dr/Mr					
Patient's Surname <u>PHILLIPS</u>	Maiden Surname				
First Names <u>WESLEY</u>	Single/Married/Widowed/Other				
Address <u>40 48, BRACSIDE DR</u>		Date of Birth <u>5/2/82</u>			
<u>BARRHEAD</u>		Patient's Occupation			
Postal Code <u>G78 2QB</u>	Contact telephone number <u>580 0223</u>				
Has the patient attended hospital before? YES / NO If "YES" please state:					
Name of Hospital <u>INVERCLYDE HOSPITAL</u>					
Year of attendance Hospital No.					
If the patient's name and/or address has/have changed since then please give details:					
Can patient attend at short notice? YES / NO					
If YES, minimum notice required days					
Name, Address and Telephone number of MEDICAL / DENTAL PRACTITIONER Dr AF Nicholson Health Centre 201 Main Street Barrhead GLASGOW, Lanarkshire G78 1SW Please use rubber stamp					

TEMPORARILY LIVING WITH FATHER SEEN AS EMERGENCY D-ICEBAR

I would be grateful for your opinion and advice on the above named patient. A brief outline of history, symptoms and signs is given below

18/10/05
3.30pm.

This young man was diagnosed as Tourette's Syndrome ~ 6 years ago. He has very low mood and a previous history of self mutilation, hands, arms + throat.

He feels very low + agitated & panic attacks since mother admitted to hospital with heart problems. He usually lives with mother. He is very afraid that he is taking a heart attack. Gets very agitated, hears his voice in head about suicide + self harm.

I would be grateful for an urgent appointment

Diagnosis / provisional diagnosis: Suicidal Ideation
Self mutilation
low mood
agitated

Carbamazepine has been prescribed by my doctor

Present drug treatment and potential special hazards: ? Compliance.

X-ray (women of childbearing age). Date of first day of L.M.P.

Relevant X-rays available from: No. (if known)

Signature [Signature]

RECEIVED
21 OCT 2005

COMMUNICATION WITH G.P. FOLLOWING EMERGENCY ASSESSMENT

PATIENT INFORMATION (please complete or affix label to all three copies of form)

Surname..... Phillips Forename..... Wesley
 Maiden name..... D.O.B..... 05.02.82 Sex ☒ M ☐ F
 Address..... 48 Brairide Dnu Unit No..... 3496
Banhead Post Code..... G78 2QB
Glasgow G78 2QB

Current Contact with Renfrewshire Psychiatric Service Y/N - if yes. Consultant..... Copy Sent

SOURCE OF REFERRAL - G.P./SW/CPN/Self/Police/Other..... Letter/Phone call

G.P. Dr Mugh Practice No..... 86336
4 Dubbs Place Port Glasgow (to be completed by Med.Rec)

REASON FOR REFERRAL

Low mood. H/O PSH

HISTORY

Diagnosed Tournell's 6 year ago.
currently staying with the father following mother's
recent admission to IRH & an MI.
Duhm likely to be caused by the above
normally lives with the mother in Greenock

MENTAL STATE

PROVISIONAL DIAGNOSIS

1..... Tournell's syndrome.
 2.....

PROPOSED MANAGEMENT/EMERGENCY MEDICATION GIVEN

Advised to register & primary GP & referral to
psychiatric op clinic for further assessment.
Chlorpromazine so my 2 doses give

DISPOSAL (please tick)

In Patient
 Alcohol Problems Clinic
 Other (specify) as above

Social Work
 CPN

Out Patient Appointment
 GP Care only

Duty Doctor's Signature.....

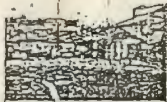
[Signature]

Time.....

3.30 am

DATE.....

18.10.05



ACUTE ADMISSION UNIT DYKEBAR HOSPITAL

NHS
Greater Glasgow
and Clyde

COMMUNICATION WITH GP/REFERRER FOLLOWING EMERGENCY ASSESSMENT

ENSURE FULL COMPLETION INCLUDING DEMOGRAPHICS ON PAGE TWO (ONLY PAGE ONE TO BE FAXED)

PATIENT INITIALS	WP	POST CODE	PA1	3	H	0
CHI	0	5	0	2	8	2
GP NAME	DR JOHNSTONE	PRACTICE CODE	8	7	6	0
GP SURGERY	NOT INCLD					
PATIENT KNOWN TO PSYCHIATRIC SERVICES		YES ☒ NO ☐				
IF YES: KNOWN TO:-		ROS				

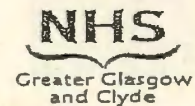
SOURCE OF THIS REFERRAL	
GP/A&E/FIRST/NHS24/NHS24 GP/REMS/CMHT/CPN/POLICE/SW/PSYCHOLOGY/SELF	
OTHER: SPECIFY-	
REASON GIVEN FOR REFERRAL	
SELF HARM / SUICIDAL THOUGHTS	
PRESENTING PROBLEM	
SEEN 16/05/12 DUE TO SUICIDAL THOUGHTS, FOR ROS FOLLOWUP.	
PRESENTED TO A&E WITH SUICIDAL THOUGHTS. LEFT AND BROUGHT BACK BY POLICE AS FOUND WITH STRING AROUND NECK BESIDE TREE. NO MARKS ON NECK.	
WALKED OUT OF PSYCHIATRIC ASSESSMENT. TAKEN INTO CUSTODY BY POLICE.	
MENTAL STATE	
UNABLE TO ASSESS	

ASSESSMENT OUTCOME (Medication/Referrals/IHTT/Admission etc)	
IN POLICE CUSTODY	
ADMITTED YES ☐ NO ☒ HOSPITAL	
TIME OF ADMISSION	
ACCEPTED FOR HOME TREATMENT YES ☐ NO ☒	
REFERRED FOR/TO - APC/ OUT PATIENT APPT/CMHT/SOCIAL WORK/POLICE	
OTHER- SPECIFY:- POLICE CUSTODY	

ASSESSORS SIGNATURE		ASSESSORS SIGNATURE	J. ELIOT
PRINT NAME	EVAN. KOSMAN	PRINT NAME	JENNIFER ELIOT
DESIGNATION	SEN. PRAC.	DESIGNATION	GPST

DATE	1	7	0	5	1	2	TIME COMPLETED	0	5	0	0
FAXED TO:	0	1	4	1	8	8	9	7	3	0	2
FAXED BY	T. CARROLLERS										
DATE	1	7	0	5	1	2	TIME				

ACUTE ADMISSION UNIT DYKEBAR HOSPITAL



Patient Surname	PHILIPS									
Forename	WESLEY									
Address	80 BALFRON RD									
Town	PAISLEY									
Post Code			P	A	I			3	H	D

THE ABOVE MUST BE COMPLETED TO ENSURE COMPLIANCE WITH MEDICAL RECORDS INFORMATION



Renfrewshire
Council

EMERGENCY ASSESSMENT REQUEST

IHTT TELEPHONE REFERRAL



Greater Glasgow
and Clyde

Date of Referral: 17/5/12		Time of Referral: 03.45	
Name: ROSELY PHILLIPS	Sex: M	DOB: 050282	CHI No: 3496
Home Address: 80 BALFORD ROAD RAISTON		GP: DR JOHNSTONE Address: NORTH AUST	
Postcode: PA1 3HD (Postcodes P1-12& P14 acceptable. P13 excluded)		Telephone No: [REDACTED]	
Telephone No: [REDACTED]		Next of Kin/S Relationship: [REDACTED]	
Mobile: [REDACTED]		Address: [REDACTED]	
Current Location If Different: A+E		Telephone No: [REDACTED]	

Referrer: DR TUCK	Agency: A+E	Tel No: 47411
Seen in last 24 hours: YES ☒ NO ☒		
Patient known to psychiatric services: YES ☒ NO ☒ NK ☒		
If yes those involved: [REDACTED]		
Legal Status:	CPA (Care Manager):	

Reason for Referral/Current Presentation

Attended A+E today really angry. Had gone to RDS for help today but felt ignored by Dr. [REDACTED]. Received no help. Left A+E threatened to end his life. Police called and brought him back. Found him with [REDACTED] moved neck [REDACTED] [REDACTED] himself.

Diagnosis: PERSONALITY DISORDER
BIPOLAR DEPENDENCY

Any children at home: YES ☒ NO ☒			
Names:	Gender	D.O.B.	Current location / carer:

History of alcohol abuse: YES ☒ NO ☒ History of drug abuse: YES ☒ NO ☒	
If yes, is patient currently under the influence of alcohol/drugs? YES ☒ NO ☒ Alcometer reading (if patient at A&E):	
KNOWN HISTORY OF AGGRESSION/VIOLENCE: YES ☒ NO ☒ Details:	
KNOWN FORENSIC HISTORY: YES ☒ NO ☒ Details:	
KNOWN HISTORY OF SELF HARM: YES ☒ NO ☒ (Overdose / cutting / other)	
CURRENT SUICIDAL THOUGHT/INTENT/PLAN: YES ☒ NO ☒ Details:	

Current medication:

Time given for patient to attend:	Procedure if patient not available for assessment:	
Location of assessment:	Contact police: Contact referrer in am: Advise on call SHO and ward staff: Other:	
Patient arrival time:		
Allocated assessors:		
INFORMED:		
Reception Staff:	YES ☒ NO ☒ Time:	
Duty Nurse:	YES ☒ NO ☒ Time:	
Duty Dr:	YES ☒ NO ☒ Time:	
Signature:	Date:	Time:

ADULT EMERGENCY ASSESSMENT

Date Assessed:

17 05 12

Time of Assessment: (24 Hour Clock)

0400

Personal Details

Surname	PHILLIPS	CHI Number	3496
Forename & Initial	WELLEY	Marital Status	SINGLE
Previous Name(s)		Legal Status	INF
Date of Birth	05.02.82	Advanced Statement	Yes ☐ No ☒
Address	80 BALFARON ROAD	Named Person	
	ADLSTON	CPA	Yes ☐ No ☒
Post Code	PA1 3DD	Religion	BAC
Telephone No.		Present Occupation	unemployed
Mobile No.	07523416947	Interpreter Required	Yes ☐ No ☒

Risk to Staff:

Next of Kin

Relationship

Address

Resides with

Relationship

Tel No.

Consent to Involve

Yes ☐

No ☐

Post Code

Dependants: Names

DOB

Telephone No.

Mobile No.

Consent to Involve

Yes ☐

No ☐

Height

6' 2"

Hair Colour

bleached blonde

Weight

110kg

Eye Colour

blue

Build

Tall lean

Distinguishing Marks

tattoo @ wrist

Sex

Male ☒

Female ☐

General Appearance

unkept

Allergies

none

Driving

Yes

No ☒

REFERRRED BY (Name):- DR TUCK

& AGENCY/DESIGNATION:- A+E RAH

CONTACT No.-

0 1 4 1 3 1 4 7 4 1 1

ASSESSMENT LOCATION: AAU/CHARLESTON CENTRE/RAH A&E/OTHER

ASSESSMENT OUTCOME

ADMISSION	YES ☐ NO ☐	CMHT REFERRAL ☐	APC REFERRAL ☐
HOSPITAL	WARD	RDS REFERRAL ☐	O/P REQUEST ☐
		IHTT YES ☐ NO ☐	

ANY OTHER INFORAMTION:

ASSESSED BY -

NAME

evah koush

NAME

Jennifer Elliott

**ADULT EMERGENCY ASSESSMENT
DYKEBAR HOSPITAL**

Existing Services involved in care (next appointment due)	
GP: <i>Dr Johnstone</i> <i>Northcraigh</i>	Psychiatric Consultant: <i>Dr Awan</i> <i>Cactus, RDS</i>
Telephone No:	Telephone No: <i>849 1223</i>
Social Worker: <i>Jacqueline Bain</i>	CPN: <i>Margaret Parkinson</i> <i>RDS</i>
Telephone No: <i>842 3020</i>	Telephone No:
Other:	Other:
Telephone No:	Telephone No:

PRESENTING PROBLEMS AND ASSESSMENT OF RISK

(as expressed by client/carer and assessor):

- Assessed at ATE last night 16/5/10 please see prev. assessment.

- Today re-referred by ATE to social location largely disorganised & services. Left ATE stating he was going to end life. Police contacted who brought him back to ATE.

PC

Staff attempted to interview patient but uncooperative "Is there any reason in me asking your stupid questions?"

Making allegations about being misled after last night's assessment plan, the receptionist at ATE, Dykebar staff stating Dr McMahon refused to see him or his very brother.

- States has offered a hotel but turned it down.

- Walked out of interview and made allegations to police about staff attitude, staff calling him a liar and not having an interest.

- Refused to cooperate with police and was subsequently arrested for Breach of the Peace & Breach of Probation of Licence.

Staff details taken by police.

Unable to complete Assessment.

ADULT EMERGENCY ASSESSMENT
DYKEBAR HOSPITAL

PREVIOUS MENTAL ILLNESS EPISODES (including history of engagement, dates of hospital admissions, detentions, past medications, history of risk eg. Suicide attempts/DSH):

previously documented 16/5/10

CURRENT MEDICATION

NAME	DOSE	FREQ	CURRENT	OTHER INFO
<i>methadone</i>	<i>50mg</i>	<i>daily</i>	<i>/</i>	<i>* from 60mg recently</i>
<i>champan</i>	<i>5mg</i>	<i>BD</i>	<i>/</i>	

ATTITUDE TOWARDS MEDICATION (including history of concordance):

ADULT EMERGENCY ASSESSMENT

DYKEBAR HOSPITAL

CURRENT HEALTH ISSUES/MEDICAL HISTORY (including any disabilities, smoking status, investigations)

Previously documented

FAMILY HISTORY (including family, education, occupation, parental/siblings relationships, childhood trauma):

father

uther

plings

Children

Family Psychiatric
 org

16/5/12
assessment

power 2
rise

SONAL HISTORY

/ Childhood

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ADULT EMERGENCY ASSESSMENT
DYKEBAR HOSPITAL

SOCIAL CIRCUMSTANCES

ACCOMMODATION and FINANCES:

previously documented

OCCUPATIONAL and DAYTIME ACTIVITIES:

PERSONAL CARE and DAILY LIVING SKILLS:

CHILD WELFARE (including Child Protection issues – physical injury, emotional abuse, sexual abuse, neglect):

RELATIONSHIP WITH OTHERS (including current support mechanisms & effect of presenting problems on relationships):

ALCOHOL and ILLICIT DRUG USE (current and past, previous detox programmes/seizures, Methadone, IV use, cigarette smoking, misuse of prescribed medications)

FORENSIC HISTORY (past and present)

ADULT EMERGENCY ASSESSMENT
DYKEBAR HOSPITAL

MENTAL STATE EXAMINATION

APPEARANCE & BEHAVIOUR:

dirty clothes, unkempt, disoriented with staff and then
walked out of the room therefore unable to
complete assessment and mental state exam

MOOD & AFFECT (Objective & Subjective):

Speech & Thought Form:

Thought / Content

Perceptual Abnormalities:

Insight:

Thought:

Information Gained from Other Sources (collaborative information):

Wishes / Expectation of Referral/Service (recovery focused):

Patient's Expressed Needs and Expectations of Referral/Service:

ADULT EMERGENCY ASSESSMENT
DYKEBAR HOSPITAL

SUMMARY (including impression, identified strengths and risks):

patient refusing to stay or cooperative. Hauled
out of room and police arrested patient
for breach of the peace.

RELEVANT STRESSORS:

PROTECTIVE FACTORS:

PLAN:



DISCUSSED WITH:

DR. LILSON

Assessors signatures:

PRINT & DESIGNATION

1:

GRAHAM KOLBACH

Senior Nurse Practitioner

2:

JENNIFER ELLIOTT

ADULT EMERGENCY ASSESSMENT
DYKEBAR HOSPITAL

HoNOS

- | | | |
|--|---|---|
| 1. Overactive, aggressive,
disruptive or agitated behaviour
{ } | 5. Physical illness or disability
problems { } | 9. Problems with relationships
{ } |
| 2. Non-accidental self-injury
{ } | 6. Problems associated with
hallucinations and delusions { } | 10. Problems with activities of
daily living { } |
| 3. Problem-drinking or drug-
taking { } | 7. Problems with depressed mood
{ } | 11. Problems with living
conditions { } |
| 4. Cognitive problems { } | 8. Other mental and behavioural
problems { } | 12. Problems with occupation
and activities { } |

TOTAL { }

Mental Health Partnership
Clinical Risk Screening and Management Tool

Service Users Name: <i>LESLIE PHILLIPS</i>	CHI N°/DoB: <i>0502 82 3496</i>	PIMS N°:
Legal Status: Informal ☒ Detained ☐ Community Order ☐	Ward /Dept / CMHT: <i>147T</i>	

Context of Assessment

On admission ☐	Engagement with Crisis Services ☒	MDT/C.P.A. review ☐
Annual review: ☐ Significant change in presentation/circumstances ☐ Other ☐ specify		

Sources of Information

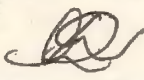
Service user ☒	Carer ☐	Consultant ☐	Other Dr ☐	Occupational Therapy ☐
Named Nurse ☐	Social Work ☐	Psychology ☐	CPN ☐	Voluntary agency worker ☐
Pharmacy ☐	GP ☐	Support worker ☐	Other ☐ specify	

Guidance

This screening form should be completed as fully as possible. It is a clinical judgement when this should take place however as a general guide this may be on admission to hospital or at the point of engagement with secondary mental health services. Thereafter it should be reviewed on a regular basis as pre-determined by the clinical team or as significant changes in circumstances or clinical presentation dictate. It is expected that reviews would routinely take place at multidisciplinary meetings, the point of transition from one aspect of service to another, as part of a planned annual review, at the point of CPA review, at the point of engagement with Crisis Services. In relation to admissions to hospital, the initial screening and formulation of risk should be reviewed at the next multi-disciplinary team meeting.

- Dependant on the information collected consideration should be given to carrying out a more detailed, specific risk assessment e.g. suicide risk assessment.
- This document should form an integral part of a comprehensive mental health assessment and care planning process, and the factors listed are not necessarily in any ranked order.
- This does not attempt to be an exhaustive list of safety issues or risk factors, merely an initial guide informing clinical management.
- The expectation that all safety risks can be predicted is unrealistic, and initial assessment may be based on incomplete information.
- If completed by one person (e.g. out of hours), this assessment should be discussed as soon as is practicable with the Consultant and multi-disciplinary team (including users and carers where appropriate).
- The assessment should include the service user and carer perspective of risk.
- The assessment must take account of parenting responsibilities and contact with children.
- Please refer to the Clinical Risk Screening & Management Policy for guidance.

Screening completed by

Print Name: <i>EVAN WILSON</i>	Signature: 
Designation: <i>SENIOR PRACTITIONER</i>	Date & Time: <i>17/5/12 05:10</i>

Mental Health Partnership
Clinical Risk Screening and Management Tool

Suicide &/or Self Harm		Violence		Other Risk Factors	
History and Situational Factors					
S1	Mental illness diagnosed or diagnosis uncertain	V1	Previous violent acts	O1	Vulnerable due to learning disability, cognitive impairment or mental illness
S2	Use of violent methods	V2	Use of weapons	O2	History of stalking others
S3	Previous self-harm	V3	Previous admission to secure units	O3	History of social, financial or sexual exploitation of others
S4	Socially isolated	V4	Convictions for violence / assault	O4	History of falls
S5	Past diagnosis of personality disorder,	V5	Past diagnosis personality disorder or psychopathy	O5	History of self-neglect,
S6	Major physical illness	V6	Alcohol or drug misuse	O6	Lacks basic housing amenities
S7	Alcohol/drug misuse	V7	Male under 35	O7	Previous fire setting
S8	Family history of suicide	V8	Prior supervision failure	O8	Socially or culturally isolated
S9	Previous treatment non-compliance	V9	Previous treatment non-compliance	O9	Neglect- children or other dependents
S10	Impulsivity	V10	Impulsivity	O10	History of exploitation by others
Short Term or Precipitating Factors					
S11	Planning suicide	V11	Intoxicated	O11	Difficulty communicating needs/views/comprehension difficulties
S12	Access to lethal method	V12	Acute psychosis	O12	Confusion or disorientation
S13	Hopeless / helpless	V13	Violent fantasies	O13	Sexually disinhibited or aggressive
S14	Recent major loss	V14	Identified target	O14	Significant financial problems
S15	Recent psych hospital discharge	V15	Access to weapons	O15	Current self-neglect
S16	Current or recent treatment non-compliance	V16	Current or recent treatment non-compliance	O16	Current neglect of children or other dependents
Protective Factors					
17	Willing to respond to advice/carers	V17	Willing to respond to advice	O17	Willing to respond to advice/carers
18	Has close relationship	V18	Appropriate services available	O18	Appropriate services available
19	Religious beliefs				

**Mental Health Partnership
Clinical Risk Screening and Management Tool**

Please write N/A if no risks identified or no risk management actions required.

Management plan

Action by:

Suicide/Self Harm

patient showing suicidal thoughts plan to harm himself
uncooperative with assessment process.

Due to the above and patient currently on
licence police arrested him to take to place
of safety (jail).

Violence

Disruptive behaviour in A&E. - ARRESTED
BY POLICE

Other Risk Factors

Outcome of screening/management plan discussed with

Service User ☐

Carer ☐

Consultant ☐

Other Dr. ☐

CPN ☐

Ward Nurse ☐

Social Work ☐

Occupational Therapy ☐

Psychology ☐

Pharmacy ☐

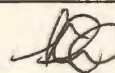
Other ☐ specify

Management Plan completed by

Print Name:

EVAN KOBAN

Signature:

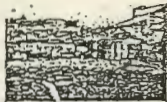


Designation:

SENIOR PRACTITIONER

Date & Time:

12/8/12 08:10



ACUTE ADMISSION UNIT DYKEBAR HOSPITAL

NHS
Greater Glasgow
and Clyde

COMMUNICATION WITH GP/REFERRER FOLLOWING EMERGENCY ASSESSMENT

ENSURE FULL COMPLETION INCLUDING DEMOGRAPHICS ON PAGE TWO (ONLY PAGE ONE TO BE FAXED)

PATIENT INITIALS	WP	POST CODE	PA1	3H0
CHI	0502823496			
GP NAME	JOHNSTONE	PRACTICE CODE	87606	
GP SURGERY	BALGON			
PATIENT KNOWN TO PSYCHIATRIC SERVICES YES ☒ NO ☐				
IF YES: KNOWN TO:- ROS / DR McMAHON				

SOURCE OF THIS REFERRAL

GP/A&E/FIRST/NHS24/NHS24 GP/REMS/CMHT/CPN/POLICE/SW/PSYCHOLOGY/SELF

OTHER: SPECIFY-

REASON GIVEN FOR REFERRAL

Suicidal Thoughts

PRESENTING PROBLEM

Argument with father. Now homeless due to fight.
Suicidal thoughts since. Wants to get help / feel better.

Significant forensic history.

Seeking hospital admission.

Does have plans for future, (college).

MENTAL STATE

Flat at times. Good rapport.

Pre-occupied with thoughts of hopelessness but keen for help.

ASSESSMENT OUTCOME (Medication/Referrals/IHTT/Admission etc)

Discussed with DR McMahon

- ROS Follow up

ADMITTED YES ☐ NO ☐

HOSPITAL

WARD

TIME OF ADMISSION

ACCEPTED FOR HOME TREATMENT YES ☐ NO ☐

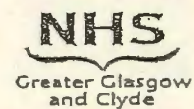
REFERRED FOR/TO - APC/ OUT PATIENT APPT/CMHT/SOCIAL WORK/POLICE

OTHER- SPECIFY:-

ASSESSORS SIGNATURE	[Signature]	ASSESSORS SIGNATURE	J. EMMOT
PRINT NAME	EVAN KOSOU	PRINT NAME	JENNIFER EMMOT
DESIGNATION	SENIOR MEDICAL	DESIGNATION	GP57

DATE	16/05/12	TIME COMPLETED	08:00
FAXED TO:	01418897502		
FAXED BY	T. CARLUTHERS		
DATE	17/05/12	TIME	

ACUTE ADMISSION UNIT DYKEBAR HOSPITAL



Patient Surname	PHILIPS									
Forename	WESLEY									
Address	80 BALFRON RD									
Town	PAISLEY									
Post Code		P	A	1		3	4	0		

THE ABOVE MUST BE COMPLETED TO ENSURE COMPLIANCE WITH MEDICAL RECORDS INFORMATION



Renfrewshire
Council

EMERGENCY ASSESSMENT REQUEST

IHTT TELEPHONE REFERRAL



Greater Glasgow
and Clyde

Date of Referral: 11/0		Time of Referral: 0500.	
Name: WESLEY PHILIPS	Sex: M	DOB: 050282	CHI No: 3496
Home Address: 80 Balfour Rd Ratston		GP: Johnstone Address: Northcroft	
Postcode: PA1 3HD. (Postcodes P1-12& P14 acceptable. P13 excluded)		Telephone No: [REDACTED]	
Telephone No: [REDACTED]		Next of Kin/Sig Relationship: [REDACTED]	
Mobile: [REDACTED]		Address: [REDACTED]	
Current Location If Different: A+E RAH		Telephone No: [REDACTED]	

Referrer: Dr. Tuck	Agency: RAH A+E	Tel No: 0141
Seen in last 24 hours: YES ☒ NO ☒		
Patient known to psychiatric services: YES ☒ NO ☒ NK ☒		
If yes those involved: Antipsychotic medication Dylabaw K Drive. Dylabaw/ Dng misuse team: Cactus. hevendale. previews admissions		
Legal Status: Conf.	CPA (Care Manager):	

Reason for Referral/Current Presentation

- Argument with Dad. Alleges Dad strangled him so he stabbed Dad with a pen. Dad accused him of killing his mother presented to A+E highlighting he would kill himself. took unbrd app to his hand, and attempted to finish his head down toilet in A+E. maintained throughout his time in A+E that he did not wish to live. Gave dog away at A+E.

Diagnosis: ?

Any children at home: YES ☒ NO ☒			
Names:	Gender	D.O.B.	Current location / carer:

History of alcohol abuse: YES ☒ NO ☒ History of drug abuse: YES ☒ NO ☒

If yes, is patient currently under the influence of alcohol/drugs? YES ☒ NO ☒

Alcometer reading (if patient at A&E):

KNOWN HISTORY OF AGGRESSION/VIOLENCE: YES ☒ NO ☒

Details:

KNOWN FORENSIC HISTORY: YES ☒ NO ☒

Details: Substantial Hx of Custodial Sentences for Vandalism, robbery.

KNOWN HISTORY OF SELF HARM: YES ☒ NO ☒

(Overdose / cutting / other)

Has taken O.D., cut wrists,

CURRENT SUICIDAL THOUGHT/INTENT/PLAN: YES ☒ NO ☒

Details: not wanting to live anymore.

Current medication: Methadone 30mls - previously on Seroquel.

Time given for patient to attend:	Procedure if patient not available for assessment:
Location of assessment: A+E	Contact police: Contact referrer in am: Advise on call SHO and ward staff: Other:
Patient arrival time:	
Allocated assessors: Graham Kearach / Sheila Kennedy	
INFORMED:	
Reception Staff: YES ☒ NO ☒ Time:	
Duty Nurse: YES ☒ NO ☒ Time:	
Duty Dr: YES ☒ NO ☒ Time:	
Signature: <i>SE Kennedy</i>	Date: 15/05/12 Time: 5.00am.

ADULT EMERGENCY ASSESSMENT

Date Assessed: 160512 Time of Assessment: (24 Hour Clock) 0500

Personal Details

Surname	PHILLIPS	CHI Number	
Forename & Initial	WESLEY	Marital Status	SINGLE
Previous Name(s)		Legal Status	Inf Review Date: 11
Date of Birth	5-2-82	Advanced Statement	Yes ☐ No ☒
Address	50 BALFROD RD	Named Person	
	RALSTON	CPA	Yes ☐ No ☒
Post Code	PA1 3TD	Religion	BAC
Telephone No.		Present Occupation	Unemployed
Mobile No.	07523416947	Interpreter Required	Yes ☐ No ☒

Risk to Staff:

Next of Kin		Resides with	
Relationship		Relationship	
Address		Tel No.	
		Consent to Involve	Yes ☐ No ☐
Post Code		Dependants: Names	DOB
Telephone No.		NONE	
Mobile No.			
Consent to Involve			

Height	6'2"	Hair Colour	BLEACHED BLONDE
Weight	UNKNOWN	Eye Colour	BLUE
Build	TALL HEAVY	Distinguishing Marks	TATTOO @ BUDDY
Sex	Male ☒ Female ☐	General Appearance	UNKempt
Allergies	NO KNOWN ALL	Driving	Yes ☐ No ☒

REFERRRED BY (Name) :- DR TUCK

& AGENCY/DESIGNATION :- ATE RAIT

CONTACT No.- 01418879111

ASSESSMENT LOCATION: AAU/CHARLESTON CENTRE/RAH A&E/OTHER ATE

ASSESSMENT OUTCOME

ADMISSION	YES ☐ NO ☒	CMHT REFERRAL	☐	APC REFERRAL	☐
HOSPITAL	WARD	RDS REFERRAL	☐	O/P REQUEST	☐
		IHTT YES	☐	NO	☐

ANY OTHER INFORAMTION: Contact RDS.

ASSESSED BY -

NAME E. Kennedy NAME

**ADULT EMERGENCY ASSESSMENT
DYKEBAR HOSPITAL**

Existing Services involved in care (next appointment due)	
GP: DR JOHNSTON NORTHURCH.	Psychiatric Consultant: DR RAJAN CACTUS.
Telephone No:	Telephone No: 0141 889 1223
Social Worker: JACQUELINE BAIN	CPN:
Telephone No: 842 3020	Telephone No: MGT PATTERSON
Other:	Other: RDS.
Telephone No:	Telephone No:

PRESENTING PROBLEMS AND ASSESSMENT OF RISK

(as expressed by client/carer and assessor):

[REDACTED] CONFLICT WITH DAD ROSE
OVER TIN OF BEANS.
YESTERDAY - POTATOES - COULD NOT BRING HOME
PAID LOAN. - IGNORES FATHERS INSTRUCTION
DAD MENTIONED DEAD MOTHER, WESLEY GRABBED
HIM, WESLEY WENT INTO KITCHEN & PUNCHED
HIS FATHER. (2) WESLEY
FATHER PUT TWO HANDS ROUND THROAT ~~HE~~
THEN STABBED HIM WITH A PEN WHICH TOOK
HANDS OF THROAT,
FATHER SAID. WESLEY 'KILLED MUM'
FRIEND
LAST COUPLE OF WEEKS GOT MURDERED
'BAD VISIONS OF WHAT I'VE SEEN - DEAD FRIEND
'MEDICATION GETTING STOPPED' - NOT HELPING
'THREW DOG OUT.' + MYSELF - 'NO WHERE TO GO'
'EVERYTHING GETTING ON TOP OF ME'
'LIFE NOT WORTH LIVING'
'FLASH BACKS OF MUM'
'STOPPED TAKING FLUETHINE / SEROQUEL.
1 WK AGO.' NO ADVERSE EFFECTS.
'WHEN I GET BETTER WILL GET MY DOG
BACK'
'I WANT TO GET MY HEAD TOGETHER'

ADULT EMERGENCY ASSESSMENT
DYKEBAR HOSPITAL

SEES HOSPITAL / JAIL WILL SORT THIS OUT.

NO ISSUES, REGARDING SLEEP OR APPETITE, TROUSERS LOOSE NOTED TO BE UNKEPT AT INTERVIEW. UNSHAVEN. WEARING DIRTY BASEBALL CAP.

IDENTIFIES HE IS MANAGING MENTAL ILL HEALTH NOT RESPONDING TO VOICES TELLING HIM TO HARM HIMSELF.

PREVIOUS MENTAL ILLNESS EPISODES (including history of engagement, dates of hospital admissions, detentions, past medications, history of risk eg. Suicide attempts/DSH):

LEVERNOLE - 4/5 NOVEMBER 2009
DEPRESSION, SEROQUEL, HALOPERIDOL
STOBHILL 2006 - DEPRESSION, HEARING VOICES. CARBAMAZEPINE, FLUOXETINE
DSH - SCARS ON FOREARMS.
OVERDOSES, 14 STITCHES TO THROAT WHILST IN PRISON PSYCHIATRIC SERVICES IN CUSTODY
8 MONTHS AGO TRIED TO PUSH MYSELF
TRIED TO HANG SELF WITH PILLOWCASES (IN PRISON)
MONTHS AGO - TOOK OVERDOSES.

CURRENT MEDICATION

NAME	DOSE	FREQ	CURRENT	OTHER INFO
METHADONE	50ml	DAILY	DA	RECENTLY REDUCED FROM 60ml.
DIAZEPAM	5mg	BD	✓	

ATTITUDE TOWARDS MEDICATION (including history of concordance):

MEDICATION DISCONTINUED DUE TO ABNORMALITY WITH HEART. HAS ATTENDED RAH FOR ECG (SEROQUEL + FLUOXETINE)
HAPPY TO TAKE ON DAILY PRESCRIPTIONS DUE TO OVERDOSE RISK.

ADULT EMERGENCY ASSESSMENT
DYKEBAR HOSPITAL

CURRENT HEALTH ISSUES/MEDICAL HISTORY (including any disabilities, smoking status, investigations)

CARDIAC ISSUES DUE PSYCHOTROPIC MEDICATION

NO KNOWN PHYSICAL PROBLEMS.

SMOKES - 10 DAILY.

FAMILY HISTORY (including family, education, occupation, parental/siblings relationships, childhood trauma):

father	DIED 2007 [REDACTED]
mother	[REDACTED]
	DIFFICULT RELATIONSHIP WITH FATHER
siblings	[REDACTED] WESLEY (30)
children	NO CONTACT WITH BROTHERS NONE
family Psychiatric history	COUSIN - [REDACTED] FATHER - [REDACTED]

PERSONAL HISTORY

Childhood	ORIGINALLY FROM PORT GLASGOW. BORN IN GERMANY - DAD IN ARMY AT THE TIME. PARENTS SUSPECTED THAT WESLEY HAD
Education	DIFFICULTIES, HYPER ACTIVE, ? HALOPERIDOL AT 17 YRS. ATTENDED CLUNARK P.S. SUSPENDED X2 TALKING BACK TO TEACHER. WENT TO
Primary/Secondary/Higher Education	PORT GLASGOW HIGH. NEVER THERE DUE TO SUSPENSIONS, ENJOYED IT WHEN HE WAS THERE SCAPEGOATED. WESLEY WOULD CRACK UP AND OTHER WOULD LAUGH AT HIM DENIES BULLYING / BEING BULLIED. MEARNS CENTRE
Relationships including psycho	WENT INTO HOME WHEN HE WAS 18 LEFT AT 16 1/2 ACHIEVED 6 STANDARD GRADES LONGEST RELATIONSHIP 5 MONTHS LAST RELATIONSHIP 2 YRS AGO
Identity	KIND HEARTED PERSON / PEOPLE TAKE A LOAN OF ME OUTGOING & FRIENDLY

ADULT EMERGENCY ASSESSMENT
DYKEBAR HOSPITAL

SOCIAL CIRCUMSTANCES

ACCOMMODATION and FINANCES:

CLAIM NFABODE FROM TODAY, FATHER HAS
THROWN HIM OUT.

DLA, ESA, PROVIDENT. \$250.00 PAYS ON
✓ 4 TIME \$40.00 2/52
MOB CARE

OCCUPATIONAL and DAYTIME ACTIVITIES:

'STOCK IN THE HOUSE'

'PLAYING COMPUTER'

'STAYING AWAY FROM FATHER'

COLLEGE COURSE - WAS DUE TO ATTEND - NOT
(COMPUTING - CARDONALD) INTERESTED NOW.

PERSONAL CARE and DAILY LIVING SKILLS:

EVIDENCE OF NEGLECT, DRESS. SHAVE ALTHOUGH
REPORTS INDEPENDENCE WITH SAME, SHOPPING,
BUDGETING & TRAVEL

CHILD WELFARE (including Child Protection issues - physical injury, emotional abuse, sexual abuse, neglect):

NONE

RELATIONSHIP WITH OTHERS (including current support mechanisms & effect of presenting problems on relationships):

DRUG ASSOCIATES - DON'T WISH TO BACK TO
LINKS WITH SERVICES.
LITTLE CONTACT WITH SIBLINGS.

ALCOHOL and ILLICIT DRUG USE (current and past, previous detox programmes/seizures, Methadone, IV use, cigarette smoking, misuse of prescribed medications)

Hx OF ILLICIT DRUG MISUSE - NO CURRENT USE.
2 VALIUM IN MARCH NO HEROIN SINCE JANUARY
DRINKS ALCOHOL 'ONCE IN A BLUE MOON'
DRINKS TO ENJOY.

FORENSIC HISTORY (past and present)

(16) 1ST ARREST BOFPEACE
(17) VANDALISM DADS HUT - 3WK REMAND
2004 - ROBBERY'S. CARRYING KNIFE
LONGEST CUSTODIAL SENTENCE 3 1/2 YRS KILMARNOCK
BARLINNIE

ADULT EMERGENCY ASSESSMENT
DYKEBAR HOSPITAL

MENTAL STATE EXAMINATION

APPEARANCE & BEHAVIOUR: 30 YR OLD MAN, LOOSE FITTING TROUSERS, DISHEVELLED/UNKEMPT QUICK TO ESTABLISH RAPPORT, GOOD EYE CONTACT, NON THREATENING, 3AT COMFORTABLE ON CHAIR.

MOOD & AFFECT (Objective & Subjective):

MOOD SUBJECTIVE 3/10
OBJECTIVE, EUTHYMIC/REACTIVE,
SPONTANEOUS.

SPEECH & THOUGHT FORM:

NORMAL RATE TONE CONTENT APPROPRIATE
COHERENT.

THOUGHT / CONTENT

PREOCCUPIED WITH ARGUMENTS WITH
FATHER.

PERCEPTUAL ABNORMALITIES:

REPORTED HEARING VOICES EARLIER TODAY
TELLING HIM TO HARM HIMSELF IDENTIFIES THAT
HE HAS MANAGED TO DEAL WITH THIS.

OBJECTIVELY - NO EVIDENCE OF DISTRACTION,
PERCEPTION: AGITATION/DISTRESS ORIENTATED,
NOT FORMALLY OBSERVED,
REPORTS GOING TO SPECIAL NEEDS
SCHOOL, LIMITED DIALOGUE AT INTERVIEW.

INSIGHT:

IDENTIFIED HE HAS BORDERLINE PERSONALITY
DISORDER & TOURETTES. - DOES NOT KNOW
MUCH ABOUT THIS.

INFORMATION GAINED FROM OTHER SOURCES (collaborative information):

NONE

PATIENT'S EXPECTATION OF REFERRAL/SERVICE (recovery focused):

NEEDS TO FEEL SAFE, WANTS TO
GET HEAD SORTED.

PATIENT'S EXPRESSED NEEDS and EXPECTATIONS OF REFERRAL/SERVICE:

NO ONE PRESENT

ADULT EMERGENCY ASSESSMENT
DYKEBAR HOSPITAL

SUMMARY (including impression, identified strengths and risks):

30 yr old man currently on licence and known to criminal justice system - long history of drug misuse, and mental health issues. Complaining of low mood and suicidal ideas however future focused about getting his life together, preoccupied with relationship with father, in particular recent argument, which was provoked by his father mentioning that he killed his mother.

RELEVANT STRESSORS:

- Homeless.
- Methodone reduced
- Family Relationships.

PROTECTIVE FACTORS:

- Dog.
- Services.
- CURRENTLY MANAGING SYMPTOMS TO AVOID.

PLAN: HURTING HIMSELF.

- Discussed with Dr McMahon.
Contact to be made with RAS to follow ~~test~~ Wesley up today.

DISCUSSED WITH:

Dr McMahon.

Assessors signatures:

PRINT & DESIGNATION

1: SKENNEY

SKenney SNP.

2:

HONOS

- TOTAL { }

Mental Health Partnership
Clinical Risk Screening and Management Tool

Service Users Name: Wesley Phillips	CHI N°/DoB: 5/2/82	PIMS N°:
Legal Status: Informal ☒ Detained ☐ Community Order ☐	Ward /Dept / CMHT: 	

Context of Assessment

On admission ☐	Engagement with Crisis Services ☒	MDT/C.P.A. review ☐
Annual review: ☐ Significant change in presentation/circumstances ☐ Other ☐ specify		

Sources of Information

Service user ☐	Carer ☐	Consultant ☐	Other Dr ☐	Occupational Therapy ☐
Named Nurse ☐	Social Work ☐	Psychology ☐	CPN ☐	Voluntary agency worker ☐
Pharmacy ☐	GP ☐	Support worker ☐	Other ☐ specify	

Guidance

This screening form should be completed as fully as possible. It is a clinical judgement when this should take place however as a general guide this may be on admission to hospital or at the point of engagement with secondary mental health services. Thereafter it should be reviewed on a regular basis as pre-determined by the clinical team or as significant changes in circumstances or clinical presentation dictate. It is expected that reviews would routinely take place at multidisciplinary meetings, the point of transition from one aspect of service to another, as part of a planned annual review, at the point of CPA review, at the point of engagement with Crisis Services. In relation to admissions to hospital, the initial screening and formulation of risk should be reviewed at the next multi-disciplinary team meeting.

- Dependant on the information collected consideration should be given to carrying out a more detailed, specific risk assessment e.g. suicide risk assessment.
- This document should form an integral part of a comprehensive mental health assessment and care planning process, and the factors listed are not necessarily in any ranked order.
- This does not attempt to be an exhaustive list of safety issues or risk factors, merely an initial guide informing clinical management.
- The expectation that all safety risks can be predicted is unrealistic, and initial assessment may be based on incomplete information.
- If completed by one person (e.g. out of hours), this assessment should be discussed as soon as is practicable with the Consultant and multi-disciplinary team (including users and carers where appropriate).
- The assessment should include the service user and carer perspective of risk.
- The assessment must take account of parenting responsibilities and contact with children.
- Please refer to the Clinical Risk Screening & Management Policy for guidance.

Screening completed by

Print Name: EWAN ICKESS	Signature: 
Designation: SENIOR PRACTITIONER	Date & Time: 16/5/12 06:30

Mental Health Partnership
Clinical Risk Screening and Management Tool

Suicide &/or Self Harm		Violence		Other Risk Factors	
History and Situational Factors					
S1	Mental illness diagnosed or diagnosis uncertain	V1	Previous violent acts	O1	Vulnerable due to learning disability, cognitive impairment or mental illness
S2	Use of violent methods	V2	Use of weapons	O2	History of stalking others
S3	Previous self-harm	V3	Previous admission to secure units <i>in 50s</i>	O3	History of social, financial or sexual exploitation of others
S4	Socially isolated	V4	Convictions for violence / assault	O4	History of falls
S5	Past diagnosis of personality disorder,	V5	Past diagnosis personality disorder or psychopathy	O5	History of self-neglect,
S6	Major physical illness	V6	Alcohol or drug misuse	O6	Lacks basic housing amenities
S7	Alcohol/drug misuse	V7	Male under 35	O7	Previous fire setting
S8	Family history of suicide	V8	Prior supervision failure	O8	Socially or culturally isolated
S9	Previous treatment non-compliance	V9	Previous treatment non-compliance	O9	Neglect- children or other dependents
S10	Impulsivity	V10	Impulsivity	O10	History of exploitation by others
Short Term or Precipitating Factors					
S11	Planning suicide	V11	Intoxicated	O11	Difficulty communicating needs/views/comprehension difficulties
S12	Access to lethal method	V12	Acute psychosis	O12	Confusion or disorientation
S13	Hopeless / helpless	V13	Violent fantasies	O13	Sexually disinhibited or aggressive
S14	Recent major loss	V14	Identified target	O14	Significant financial problems
S15	Recent psych hospital discharge	V15	Access to weapons	O15	Current self-neglect
S16	Current or recent treatment non-compliance	V16	Current or recent treatment non-compliance	O16	Current neglect of children or other dependents
Protective Factors					
S17	Willing to respond to advice/carers	V17	Willing to respond to advice	O17	Willing to respond to advice/carers
S18	Has close relationship	V18	Appropriate services available	O18	Appropriate services available
S19	Religious beliefs				

**Mental Health Partnership
Clinical Risk Screening and Management Tool**

Please write N/A if no risks identified or no risk management actions required.

Management plan	Action by:
Suicide/Self Harm Reports long hx of suicide attempts by hanging, cutting throat required 14 stitches Describes he of taking 500, attempts hanging himself in prison - reports suicidal thoughts with no specific plans because he puts himself homeless after fighting with father tonight & was thrown out of his dog. - clearly states wants help "no body wants to die" "I'd like to sort things out and get my dog back" - contact CACTUS, RDS KEYWORKER + criminal justice team	DR ENHLOTT DR ARMSTRONG
Violence - Reports a long hx of offending behaviours. - 3x Robberies, extensive time spent in jail - currently on licence - known to criminal justice team, CACTUS - PHYSICAL FIGHT TONIGHT WITH FATHER CLAIMS DAD WAS HOLDING HIM BY THE THROAT SO USED A PEN TO STAB FATHER.	
Other Risk Factors	

Outcome of screening/management plan discussed with

Service User ☐

Carer ☐

Consultant ☒

Other Dr. ☐

CPN ☐

Ward Nurse ☐

Social Work ☐

Occupational Therapy ☐

Psychology ☐

Pharmacy ☐

Other ☐ specify

Management Plan completed by:

Print Name:

EVAN KORSAN

Signature:



Designation:

SENIOR PRACTITIONER

Date & Time:

16/5/12



ACUTE ADMISSION UNIT DYKEBAR HOSPITAL

NHS
Greater Glasgow
and Clyde

(F)

COMMUNICATION WITH GP/REFERRER FOLLOWING EMERGENCY ASSESSMENT

ENSURE FULL COMPLETION INCLUDING DEMOGRAPHICS ON PAGE TWO (ONLY PAGE ONE TO BE FAXED)

PATIENT INITIALS	IWP	POST CODE	PA11	810											
CHI	0	5	0	2	8	2	3	4	9	0					
GP NAME	DR MITCHELL					PRACTICE CODE					8	7	6	0	6
GP SURGERY	BARRHEAD Health Centre														
PATIENT KNOWN TO PSYCHIATRIC SERVICES YES ☒ NO ☐															
IF YES: KNOWN TO:- ROS															

SOURCE OF THIS REFERRAL

GP / A&E / FIRST / NHS24 / NHS24 GP / REMS / CMHT / CPN / POLICE / SW / PSYCHOLOGY / SELF
OTHER : SPECIFY-
REASON GIVEN FOR REFERRAL

'suicidal'

PRESENTING PROBLEM

Homeless since Monday - argument - dad - throw out home
2x presentation to Dykebar - 51 - physical plan - aggressive to police cells last night & NHS.
Today - feeling 'down' - thinking about mother's death - "because I was funding her out". How felt needed for 'years' 'don't want to die but help'. Stating after assessment 'I'm going to see my lawyers next week to sue psychiatry for not helping me'. No perceptual disturbances. No evidence of affective dx. No action taken - plan next wk.
MENTAL STATE
A+B - Aggressive - good EC/EE - firm & distracted
M+A - (M) 'unhappy' (A) aggressive / reactive
S+IE - Speech varying rate/rhythm/volume & etc.
IC - emotional distress - active suicidal - fleeing but & action taken - plan next wk
P - denies - evidence of
I - intact
C - intact

ASSESSMENT OUTCOME (Medication/Referrals/IH/TT/Admission etc)

- Offered homeless at Hillhead Hotel Glasgow - refused - stating going home to dad's house.
- Offered admission - refused
- Advised - attend old man & enjoy in team - refused (not going back)
- Aggressive at check in - leaving.

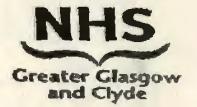
ADMITTED YES ☐ NO ☒	HOSPITAL	WARD
TIME OF ADMISSION		
ACCEPTED FOR HOME TREATMENT YES ☐ NO ☒		
REFERRED FOR/TO - APC/ OUT PATIENT APPT/CMHT/SOCIAL WORK/POLICE		
OTHER - SPECIFY:-		

ASSESSORS SIGNATURE		ASSESSORS SIGNATURE	
PRINT NAME	MITCHELL	PRINT NAME	CLARA KORSAH
DESIGNATION	CT2	DESIGNATION	IHT

DATE	1	9	0	5	1	7	TIME COMPLETED	0	0	4	7
------	---	---	---	---	---	---	----------------	---	---	---	---

FAXED TO:	0	1	4	1	3	1	4	0	8	3	9
FAXED BY:	ERICA ROWE										
DATE	2	1	0	5	1	2	TIME				

ACUTE ADMISSION UNIT DYKEBAR HOSPITAL



Patient Surname	PHILIPS									
Forename	WESLEY									
Address	80 BALFRON RD									
Town	PM8 2J									
Post Code		P	A	1			3	H	D	

THE ABOVE MUST BE COMPLETED TO ENSURE COMPLIANCE WITH MEDICAL RECORDS INFORMATION

Reason for Referral/Current Presentation

Was taken to police yesterday the other day - had to
hang self and was taken in for safety
recent fell out with dad - dad put him out of house

Diagnosis: B.P.D.

Any children at home: YES ☐ NO ☒			
Names:	Gender	D.O.B.	Current location / carer:

History of alcohol abuse: YES ☐ NO ☐ Past ☐ Present ☐ *N/K.*
History of drug abuse: YES ☒ NO ☐ Past ☒ Present ☐ *ON METARDONE*
If yes, is patient currently under the influence of alcohol/drugs? YES ☐ NO ☒
Alcometer reading (if patient at A&E):
(Consider Public Disorder) **CONSIDER ASSESSMENT AT DYKEBAR** ☐

KNOWN HISTORY OF AGGRESSION/VIOLENCE :
YES ☒ NO ☐ Past ☐ Present ☐ *N/K*
Details: *Pt claims to G.P. that he stabbed his father in the face a few days ago*
Potentially dangerous to others ☐ **CONSIDER ASSESSMENT AT DYKEBAR** ☐

KNOWN FORENSIC HISTORY :
YES ☒ NO ☐ Past ☐ Present ☐ *N/K*
Details: *VILLMARNOCK PRISON AUG 2011 (21 MONTHS PRISON)*
Potentially dangerous to others ☐ **CONSIDER ASSESSMENT AT DYKEBAR** ☐

KNOWN HISTORY OF SELF HARM : YES ☒ NO ☐
(Overdose / cutting / other) *SUMPS IN FRONT OF CARS*

CURRENT SUICIDAL THOUGHT/INTENT/PLAN : YES ☒ NO ☐

WILL PATIENT BE ESCORTED BY POLICE OR AMBULANCE : YES ☐ NO ☒
Assess at Dykebar if yes

HAS REFERRER BEEN INFORMED AND ACKNOWLEDGED THAT PATIENT WILL BE UNSUPERVISED UNTIL START OF ASSESSMENT: YES ☒ NO ☐

Current medication: *METARDONE 55ml.*
QUETIAPINE - RECENTLY STOPPED BY MEDICS (WAS 30067)
DIAZEPAM 5mg B.D. (for last 10 days)

Time given for patient to attend: <i>22.00</i>	Procedure if patient not available for assessment:
Location of assessment: <i>Adm.</i>	Contact police: Contact referrer in am: Advise on call SHO and ward staff: Other: <i>FATHER (NUMBER OVERLEAF)</i>
Patient arrival time:	
Allocated assessors:	

INFORMED:

Reception Staff:	YES ☐ NO ☐	Time:
Duty Dr:	YES ☐ NO ☐	Time:

Signature:	Date:	Time:
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ADULT EMERGENCY ASSESSMENT

Date Assessed: 180512 Time of Assessment: (24 Hour Clock) 0000

Personal Details			
Surname	PHILLIPS	CHI Number	3490
Forename & Initial	WENLEY	Marital Status	SINGLE
Previous Name(s)		Legal Status	INF Review Date: / /
Date of Birth	05.02.82	Advanced Statement	Yes ☐ No ☒
Address	80 BOLTON RD PAISLEY	Named Person	NONE
Post Code	PA1 340	CPA	Yes ☐ No ☒
Telephone No.		Religion	B.D.C
Mobile No.		Present Occupation	Unemployed
		Interpreter Required	Yes ☐ No ☐
		Adult at Risk AP1 Form	Yes ☐ No ☐
Risk to Staff:			
Next of Kin		Resides with	
Relationship		Relationship	
Address		Tel No.	
		Consent to Involve	Yes ☐ No ☐
Post Code		Dependants: Names	
Telephone No.		DOB	
Mobile No.			
Consent to Involve	Yes ☐ No ☒		
Height	6'1"	Hair Colour	BROWNED
Weight	UNKNOWN	Eye Colour	BLUE SHORT
Build	LARGE	Distinguishing Marks	
Sex	Male ☐ Female ☒	General Appearance	
Allergies	NONE KNOWN	Driving	Yes ☐ No ☐
REFERRED BY (Name) :- DR JOHNSTONE			
& AGENCY/DESIGNATION :- GP			
CONTACT No.-			
ASSESSMENT LOCATION: _____			
ASSESSMENT OUTCOME			
ADMISSION	YES ☐ NO ☐	CMHT	YES ☐ NO ☐
HOSPITAL	WARD	OUT PATIENT REQUEST	YES ☐ NO ☐
		IHTT	YES ☐ NO ☐
ANY OTHER INFORMATION:			
As per RQ			
ASSESSED BY -			
NAME	GAIL KERR	NAME	FIONA MITCHELL

ADULT EMERGENCY ASSESSMENT
DYKEBAR HOSPITAL

Existing Services involved in care (next appointment due)	
GP: DR JOHNSTONE BARONY MP	Psychiatric Consultant: DR M. MAHON RDS
Telephone No:	Telephone No: 889 1223
Social Worker:	CPN: MARGARET PARKINSON RDS
Telephone No:	Telephone No:
Other:	Other:
Telephone No:	Telephone No:

PRESENTING PROBLEMS AND ASSESSMENT OF RISK

(as expressed by client/carer and assessor):

Ref by DR JOHNSTONE G.P today where patient had presented
completing suicidal thoughts due to having no fixed abode.
Advised to attend dykebar for assessment tonight.

DC

- CAME OUT OF JAIL TODAY AND WENT TO SEE GP
- STATES HAS BEEN STRUGGLING FOR LAST FEW YEARS WITH SUICIDAL IDEAS
BUT SINCE BECOMING HOMELESS ON MONDAY NOW FEELS SUICIDAL

TRIGGERS

- MOTHER'S DEATH 1 1/2 MONTHS AGO
- MOTHER'S DEATH SEEN YEARS AGO & BEING BLAMED BY FAMILY FOR HER DEATH
- FRIEND ASSAULTED IN OCT 2011
- FIGHT WITH DAD AT THE WEEKEND & FATHER BLAMING HIM FOR
HER DEATH.

NOW

- SUICIDAL THOUGHTS HAS ATTEMPTED TO COMPLETE SUICIDE BY
- PUSHING A HEAD IN TOILET SEEN AT ATE TUESDAY NIGHT
- PICKED UP BY RDS + KEY WORKER WEDS ATTENDED RDS OFFERED
HOSTEL NOT HAPPY WITH THIS.
- ATTENDED ATE WEDS NIGHT ANGRY & DISORIENTED WITH FOUR UP
PLAN & SERVICES ABANDONED THEN POLICE PICKED HIM UP.
- WEDS NIGHT ARRESTED BY POLICE AT ATE B.O.P & UNCOOPERATIVE
WITH

- NOT HAPPY LIVING IN BTB OFFERED TODAY AT HILLHEAD HOTEL GLASGOW
LOOKING FOR HELP NOW I.E CPN WHICH HE WAS APPARENTLY PROMISED
AS PART OF BEING ON LICENCE FROM JAIL. LIBERATED 5/12 AND

**ADULT EMERGENCY ASSESSMENT
DYKEBAR HOSPITAL**

RISKS

- TRIED TO END HIS LIFE IN POLICE CELL WHILE ON OBSERVATIONS WITH RELIANCE STAFF OUTSIDE BY USING A JACKET. NO EVIDENCE OF SAME ON SKIN
- DESCRIBES SUICIDAL THOUGHTS FOR YEARS AND ATTEMPTS TO END LIFE BY LYING ON STREET FOR VEHICLES TO RUN HIM OVER, DSH BUT THAT NO ONE LISTENS TO HIM AND CALL HIM A LIAR INSTEAD SO FED UP
- DISPLAYED DRUG SEEKING BEHAVIOUR REQUESTING FOR DIAZEPAM AND WHEN THIS WAS DECLINED BECAME ANNOYED THREATENING TO SEE HIS LAWYERS TO Sue HEALTH BOARD AND STATED DID NOT WISH FOLLOW UP FROM ANY PSYCHIAL SERVICES INCLUDING RES
- DENIES USE OF ANY ALCOHOL OR DRUGS

PREVIOUS MENTAL ILLNESS EPISODES (including history of engagement, dates of hospital admissions, detentions, past medications, history of risk eg. Suicide attempts/DSH):

WELL DOCUMENTED ON K DRIVE AND PREVIOUS ASSESSMENTS OF 15/5/07 AT AGE 47 AND 16/5/12 AT AGE 48 WHERE MR PHILLIPS WAS ARRESTED FOR B.O.P.

CURRENT MEDICATION

NAME	DOSE	FREQ	CURRENT	OTHER INFO
DIAZEPAM	5MG	BD	DAILY	DISPENSED
ALL OTHER MEDICATIONS STOPPED RECENTLY BY DR GUNANDEE.				
QUETIAPINE AND FLUOXETINE.				
METHADONE	50MG	BD	DAILY	DISPENSED.

ATTITUDE TOWARDS MEDICATION (including history of concordance):

STATE DOES NOT FEEL BENEFIT OF DIAZEPAM BUT REQUESTING FOR MORE TO BE DISPENSED TONIGHT

**ADULT EMERGENCY ASSESSMENT
DYKEBAR HOSPITAL**

CURRENT HEALTH ISSUES/MEDICAL HISTORY (including any disabilities, smoking status, investigations)

FAMILY HISTORY (including family, education, occupation, parental/siblings relationships, childhood trauma):

Mother

Father

Siblings

Children

Family Psychiatric
History

*previously
documented
15/5/12*

PERSONAL HISTORY

Birth / Childhood

School / Education

Primary/
Secondary
Qualifications

Occupations

Relationships
(including psycho
sexual)

Premorbid
Personality

ADULT EMERGENCY ASSESSMENT
DYKEBAR HOSPITAL

SOCIAL CIRCUMSTANCES
ACCOMMODATION and FINANCES:
Offered homeless accommodation in a hostel in Glasgow
OCCUPATIONAL and DAYTIME ACTIVITIES:
WATCHING TV
PERSONAL CARE and DAILY LIVING SKILLS:
NO PROBLEMS WITH ADLS
CHILD WELFARE (including Child Protection issues – physical injury, emotional abuse, sexual abuse, neglect):
N/A
RELATIONSHIP WITH OTHERS (including current support mechanisms & effect of presenting problems on relationships):
STATES WAS THROWN OUT OF HOME BY FATHER BUT REST OF FAMILY ARE UNSUPPORTIVE BUT WAS SEEN ON PAYPHONE TALKING TO SOMEONE. HE INFORMED STAFF IT WAS HIS FATHER AND WAS GOING HOME TO HIM.
ALCOHOL and ILLICIT DRUG USE (current and past, previous detox programmes/seizures, Methadone, IV use, cigarette smoking, misuse of prescribed medications)
Denies current use of illicit or alcohol.
FORENSIC HISTORY (past and present)
LONG HX DOCUMENTED ON 15/5/12

ADULT EMERGENCY ASSESSMENT
DYKEBAR HOSPITAL

MENTAL STATE EXAMINATION
APPEARANCE & BEHAVIOUR: <i>Aggressive posture as distressed. Threatening & have performed of outcome of assessment contrary to wishes. Good eye contact.</i>
MOOD & AFFECT (Objective & Subjective): <i>Sub 'Annoyed'</i> <i>Obj annoyed aggressive & negative</i>
SPEECH & THOUGHT FORM: <i>varying rate / rhythm & volume</i>
THOUGHT / CONTENT <i>N.F.T.O</i> <i>Content of discontent with services and irritation with same.</i>
PERCEPTUAL ABNORMALITIES: <i>denies any evidence to suggest otherwise</i>
COGNITION: <i>intact</i>
INSIGHT: <i>intact</i>
INFORMATION GAINED FROM OTHER SOURCES (collaborative information): <i>IC Drive.</i>
CLIENTS EXPECTATION OF REFERRAL/SERVICE (recovery focused): <i>unable to state "can't tell" you how to do your job.</i>
CARER'S EXPRESSED NEEDS and EXPECTATIONS OF REFERRAL/SERVICE: <i>will present.</i>

**ADULT EMERGENCY ASSESSMENT
DYKEBAR HOSPITAL**

SUMMARY (including impression, identified strengths and risks):

30 year old male presenting for the 3rd time 904 complaining of chronic suicidal thoughts worsened by social stressors as well as N.E.D. unhappy with offer by hospital accommodation. Known to addiction services with good record in place and extensive history of offending behaviour. Displayed drug seeking behaviour and, left threatening to sue Health Board and returned to father's home.

RELEVANT STRESSORS:

Recently homeless following fight with father with whom he normally resides.

PROTECTIVE FACTORS:

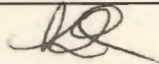
PLAN: OFFERED TRANSPORTATION TO HOMELESS ACCOMMODATION TONIGHT & FOLLOW UP THROUGH ROS + SOCIAL WORKER ON MONDAY BUT DECLINED THIS STATING HE'S GOING TO SUE THE HEALTH BOARD FOR NOT MEETING HIS NEEDS. PLANS TO SEE A LAWYER ABOUT THIS.

- REQUESTED TO BE GIVEN DIAZEPAM FOR THE WEEKEND AND WHEN THIS WAS DECLINED WITH EXPLANATION GIVEN BECAME UNHAPPY AND STATED HE NO LONGER WISHED ANY FOLLOW UP FROM ROS ETC.
- AFTER TAXI WAS ORDERED TO HOMELESS ACCOMMODATION DECLINED STATING HE WAS GOING TO HIS FATHERS HOUSE.

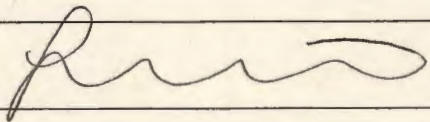
DISCUSSED WITH:

DR LUNNIGTON.

Assessors signatures:



PRINT & DESIGNATION

1:	Smithell CTG	
2:	Ewan Kwan	SEAN PENNITVER

HoNOS

- TOTAL { }

**Mental Health Partnership
Clinical Risk Screening and Management Tool**

Please write N/A if no risks identified or no risk management actions required.

Management plan

Action by:

Suicide/Self Harm

PAULUS DSH PLUS

THIS WEEK

STATES TO HAVE MADE ATTEMPTS TO END HIS LIFE BY
FLUSHING HERO IN TOILET, HANGING USING JACKET IN BATH
WHILST OBSERVED BY RELIANCE STAFF AND POLICE.

- DESCRIBED SUICIDAL ~~THOUGHTS~~ TO STAFF WITH VAGUE
PLANNING BUT WHEN INFORMED OF FOLLOW UP PLAN
BECAME ANGRY WITH STAFF AND THREATENED ~~FOR~~ TO
SUE THE HEALTH BOARD.

Violence

- DISPLAYED DRUG SEEKING BEHAVIOUR ^{BY} REQUESTING
FOR DIAZEPAM AND WHEN IT WAS DECLINED ~~EXPLANATION~~
WHEN BECAME UNHAPPY & REFUSED ANY MORE INTERVENTIONS
FROM PSYCHIATRIC SERVICES.

- WAS OFFERED TAXI TO HOMELESS ACCOMMODATION IN
GLASGOW AND AFTER THIS HAD BEEN ORDERED
AFTER HE HAD TALKED TO FRIEND ON PAY PHONE

Other Risk Factors

DECLINED IT STATING HE WAS GOING HOME
INSTEAD.

- DR MITCHELL TO UPDATE KEYWORKER AT ROS
ON MONDAY RE EVENTS.

Outcome of screening/management plan discussed with

Service User ☒

Carer ☐

Consultant ☒

Other Dr. ☐

CPN ☐

Ward Nurse ☐

Social Work ☐

Occupational Therapy ☐

Psychology ☐

Pharmacy ☐

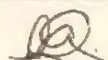
Other ☐ specify

Management Plan completed by

Print Name:

EVAN KURAH

Signature:



Designation:

SENIOR PRAGTITIONER

Date & Time:

19/5/12 01:00

Mental Health Partnership
Clinical Risk Screening and Management Tool

Service Users Name: <i>LESLIE PAULUS</i>	CHI N°/DoB: <i>0502823496</i>	PIMS N°:
Legal Status: Informal ☒ Detained ☐ Community Order ☐	Ward /Dept / CMHT: <i>14T5</i>	

Context of Assessment

On admission ☐	Engagement with Crisis Services ☒	MDT/C.P.A. review ☐
Annual review: ☐ Significant change in presentation/circumstances ☐ Other ☐ specify		

Sources of Information

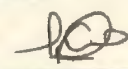
Service user ☒	Carer ☐	Consultant ☐	Other Dr ☐	Occupational Therapy ☐
Named Nurse ☐	Social Work ☐	Psychology ☐	CPN ☐	Voluntary agency worker ☐
Pharmacy ☐	GP ☒	Support worker ☐	Other ☐ specify	

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Screening completed by

Print Name: <i>EWAN KILGALL</i>	Signature: 
Designation: <i>SERVICE PRACTITIONER</i>	Date & Time: <i>19/05/12 01:00</i>

Mental Health Partnership
Clinical Risk Screening and Management Tool

Suicide &/or Self Harm		Violence		Other Risk Factors	
History and Situational Factors					
S1	Mental illness diagnosed or diagnosis uncertain	V1	Previous violent acts	O1	Vulnerable due to learning disability, cognitive impairment or mental illness
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S3	Previous self-harm	V3	Previous admission to secure units <i>RM502</i>	O3	History of social, financial or sexual exploitation of others
S4	Socially isolated	V4	Convictions for violence / assault	O4	History of falls
S5	Past diagnosis of personality disorder,	V5	Past diagnosis personality disorder or psychopathy	O5	History of self-neglect,
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S7	Alcohol/drug misuse	V7	Male under 35	O7	Previous fire setting
S8	Family history of suicide	V8	Prior supervision failure	O8	Socially or culturally isolated
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S10	Impulsivity	V10	Impulsivity	O10	History of exploitation by others
Short Term or Precipitating Factors					
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S12	Access to lethal method	V12	Acute psychosis	O12	Confusion or disorientation
S13	Hopeless / helpless	V13	Violent fantasies	O13	Sexually disinhibited or aggressive
S14	Recent major loss	V14	Identified target	O14	Significant financial problems
S15	Recent psych hospital discharge	V15	Access to weapons	O15	Current self-neglect
S16	Current or recent treatment non-compliance	V16	Current or recent treatment non-compliance	O16	Current neglect of children or other dependents
Protective Factors					
S17	Willing to respond to advice/carers	V17	Willing to respond to advice	O17	Willing to respond to advice/carers
S18	Has close relationship	V18	Appropriate services available	O18	Appropriate services available
S19	Religious beliefs				

0502823496.

NHS GREATER GLASGOW & CLYDE - MENTAL HEALTH CARE PLAN

CHRONOLOGICAL ACCOUNT OF CARE

PIMS No/CHI No:	3296.	WARD:	I.H.T.I
NAME:	WESLEY PHILLIPS.		
ADDRESS:	80 BALFRAN ROAD PAISLEY		
POST CODE:	PA1 3DH.		
DOB & GENDER:	050282 MALE		

DATE & TIME	THE CHRONOLOGICAL ACCOUNT OF CARE IS A COMPLETE RECORD OF THE PATIENT'S JOURNEY FROM ADMISSION TO DISCHARGE. IT WILL ENCOMPASS ADMISSION STATEMENTS/DETAILS, EVALUATIONS, UPDATES, REVIEWS, MULTIDISCIPLINARY DECISIONS AND RECORDINGS OUT-WITH FORMAL MDT. EACH ENTRY MUST BE TITLED WITH A HEADING OF THE RECORDINGS. EG CARE PLAN REVIEW, EVALUATION, ONE TO ONE CONTACT. IT IS THE DUTY OF ALL REGISTERED NURSES TO REFER BACK TO THE INTERVENTIONS FOR EVALUATION PURPOSES.	SIGNATURE, PRINT NAME & DESIGNATION
21/05/11	Phone call received from Mr Phillips - father of patient noted above.	
1520.	Mr Phillips - (No first name given)	
	Sounded disgruntled about psychiatric service in general.	
	States son has had 4 assessments and has been sent home with no help despite ongoing long term suicidal ideation.	
	"Since age of seven" "Your services are a waste of time."	
	My son keeps telling me he wants to kill himself.	
	"I'm fed up with you's doing nothing"	
	Mr Phillips stating his son voiced suicidal ideation last week and nothing has changed."	
	During conversation I attempted to offer as much support as I could, offering crisis	

DATE & TIME	EACH ENTRY MUST BE TITLED WITH A HEADING OF THE RECORDINGS EG. CARE PLAN REVIEW, EVALUATION, ONE TO ONE CONTACT.	SIGNATURE, PRINT NAME & DESIGNATION
21/05/12	numbers etc. - Plus ways of cont. setting access to service via	
	gp, police, A+E etc. + arranged contact with RDS.	
	However Mr Phillips not taking information on board and	
	becoming verbally hostile and continually derogatory toward	
	psychiatric service as a whole.	
	Son with Mr Phillips today.	
	and being supported by his dad.	
	Offered dad means of complaint,	
	"I've done that, it was swept under the carpet."	
	Generally frustrated sounding throughout conversation	
	with Mr Phillips encouraging him to offer information for	
	his son to re access services as req'd	
	S. Paine	KIDOCK KIDOCK

ADMISSION RECORD PSYCHIATRY

Copies: white - Nursing
yellow - Medical Records
green - Medical Records Dept.
pink - Social Work Dept.

HOSPITAL *RAH* Ward *3*
CONSULTANT *DR ANDERSON* Day *SUNDAY*
HOSPITAL NUMBER *0502823496*
DATE OF CURRENT ADMISSION Day *29* Month *01* Year *06*

Surname (Block Letters) *PHILLIPS* ☒ Mr ☐ Mrs / Miss

FORENAMES *NESLEY*

MAIDEN SURNAME

SEX *MALE* AGE *23YR* DATE OF BIRTH Day *5* Month *02* Year *82*

PRESENT MARITAL STATE: ☒ Never Married / Married /
☐ Widowed / Divorced / Separated / Not Known

HOME ADDRESS *45 PROSPECTHILL COURT
GREENOCK*

OCCUPATION () *LINE EMPLOYED*
()

- a) Occupation of patient.
b) If retired, enter last normal occupation.
c) If under 18 years, or never employed, enter parent's or guardian's occupation
d) If married, enter husband's occupation.

NATIONAL HEALTH SERVICE NUMBER

RELIGION *PROT*

TIME OF ADMISSION *04 50HR*
TYPE OF ADMISSION *EMERGENCY*
STATUS ON ADMISSION *INFORMAL*
REFERRED TO HOSPITAL BY *SELF*
MODE OF TRANSPORT *AMBULANCE*
RESIDENCE IMMEDIATELY PRIOR TO ADMISSION *HOME*

PREVIOUS HOSPITAL CARE
Hospital / s *INVERCLYDE*
Year / s *LAST ADMISSION 1998*

Name of General Practitioner *DR MUTCH*
Address *DUBBS RD
MEDICAL CENTRE
PORT GLASGOW*
Telephone Number

EPILEPSY PRESENT: Yes ☐ No ☒
DIABETES PRESENT: Yes ☐ No ☒
SPECIAL HAZARDS (E.G. Drug allergies, etc.)
NONE

OTHER

CHANGE OF STATUS
Date
To

DATE OF DISCHARGE Day *30* Month *1* Year *06*
To *Home*

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Name
Rela
Addr
Telep

NATIONAL INSURANCE NUMBER
TD 45 23 76 A
PENSION / ALLOWANCE *DLA*
Type *INCOME SUPPORT* Number

MONEY AND / OR VALUABLES LODGED Yes ☒ No ☐

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NHS ARGYLL AND CLYDE

FLOW CHART FOR DETAINED PAIENTS

THIS FORM MUST BE THOROUGHLY COMPLETED FOR ALL PATIENTS
DETAINED UNDER THE MENTAL HEALTH ACT.

Patient's Name:	NEDLEY PHILLIPS																
C.H.I.	0	5	0	2	8	2	3	4	9	6	Date Of Admission:	2	9	0	1	0	6
Consultant:	DR ANDERSON																

SECTION 24/ 25* Delete As Necessary			
Doctors Name			
M.H.O. Name			
Date:		Time:	

INFORMAL	
Date:	
Time:	IF SPECIFIED BY CONSULTANT

72 Hours After 24/25			
SECTION 26			
Date Due		Time Due	
Doctors Name			
M.H.O. Name			
Date Applied		Time Applied	

28 DAYS AFTER 26 Section 26 remains in force until Section 18
granted or not. No matter how long it takes

CAN ONLY BE USED WITHIN LAST 48 Hrs of Section 26			
SECTION 26A			
Date Applied		Time Applied	
Doctors Name			
M.H.O. Name			

Medical Records **MUST** be informed immediately (or their next working
day) as they have to personally deliver Section to the Court.
Section 18 papers must be lodged @ Court within 3 working days of
application of Section 26A

SECTION 18	
Date Due	

R.M.O. FORM 3	G.P. or Other consultant FORM 3	M.H.O. REPORT
R.M.O. Name	Dr. Name	M.H.O. Name
Date Completed	Date Completed	Date Completed

PATIENT'S LEGAL REPRESENTATIVE	
Lawyer's Name:	
Phone No:	

SECTION 18 GRANTED	
Date:	

Applied @ Midnight on day it is granted.

4 Weeks after granting of 18		
FORM D (4/52 Review)		
Due Between		
Date:	&	Date:
Doctors Name:		
Date Completed:		

6 Calendar Months minus 1 day after granting of 18	
FORM 4 (6 Monthly Review)	
Date Due:	
Doctors Name:	
Date Completed:	

12 weeks after granting of 26	
FORM 9/10* Delete as approp.	
Date Due:	
Completed By:	
Date Completed:	

FORM 10 (2nd Opinion)			
Completed by Dr.		Date	
Copy sent to Med. Records:			
Date & Sign			

LEAVE OF ABSENCE	
Date Left	

Nursing Staff must ensure that at all major
junctures the patient's Care Plan pertaining
to their detention must be updated to match.

Clothing and valuables advice

On admission to Dykebar Hospital Acute unit a member of staff will check your clothing and valuables. This is a safety check and does not constitute the Trust taking responsibility for your clothing and valuables.

Liability can only be accepted for items that are accepted for safe keeping and formally receipted.

All other items are kept at your own risk. We advise that any items of value are not kept within the hospital.

Signed (patient):

Signed (member of staff):

Print Name ROBERT LINDSAY

Date:

Patient's Name WESLEY PHILLIPS

Chi No./unit No.: 29/01/06

Clinical Area HD 2

**ARGYLL & CLYDE HEALTH BOARD
GREATER RENFREWSHIRE DIVISION
ADULT MENTAL HEALTH**

**AGREEMENT TO PREVENT THE ABUSE OF ALCOHOL AND
DRUGS WHILST AN IN-PATIENT**

Patient Name	WESLEY PHILLIPS	Date of Birth						Date of Signing					
		0	5	0	2	8	2	2	9	0	1	0	6

In the interests of yourself and others please read the following statements and sign to show your understanding and agreement.

I WILL NOT

Take any illegal (including cannabis) or non-prescribed substance, including alcohol whilst an in patient.

Supply any illegal (including cannabis) or non-prescribed substance, including alcohol to any other person within the hospital.

I WILL

Agree to take a breathalyser test as and when requested by staff.

Agree to give a urine specimen for drug testing as and when required by staff.

Agree to staff searching my belongings should they suspect that I have illicit or non-prescribed substances or alcohol.

If any of the above tests or search prove positive

Or

If I refuse to allow these tests or search to be carried out

Or

I attempt to unnecessarily delay these tests being carried out

My status as an in-patient will be reviewed and I may be immediately discharged. Also, dependant on the circumstances staff may notify the police.

Patient's Signature :

--

I have discussed the above with the patient.

Staff Signature:

Isobell Lindsay

NHS ARGYLL & CLYDE
DYKEBAR HOSPITAL
PHARMACY DEPARTMENT

Patients Own Medicine – Patients consent Form

Dear *Mrs. J. J.*.....

Thank you for bringing your medicine into hospital with you. This is very helpful to us as it provides us with confirmation of the medicines you are taking at home.

The purpose of this letter is to allow you to give us consent to either

- Use your medicines for your treatment, if appropriate, during your stay in hospital

Or

- To destroy your medicines safely.

You have the right to refuse this in which case your medicines will be kept for you on the ward and returned to you on discharge.

However, during your stay in hospital, the medicines you have to take may be changed or some of the medicines you were taking stopped in which case for your safety we would wish to destroy those medicines.

When you are discharged from hospital, you will be given a supply of medicines from the pharmacy department. This will usually be a seven day supply.

If you are happy for us, if necessary, to use your medicines (for your treatment only) or to destroy any no longer suitable for you, please sign below.

Signed.....Date.....
(Patient/representative)

PLEASE FILE IN PATIENTS CASE NOTES PRIOR TO DISCHARGE



Contact secretaries at 44284

Giving:- Patients Name *Nesley PHILLIPS*

D.O.B. *05/02/82*

Consultant *DR ANDERSON*

Section Details *INFORMAL*

Signed *J. Lundberg*

Date *29/1/06*

Time *05.20 AM*

**NHS Argyll & Clyde
Admission Record**

Patient Identification:		Forename(s) <u>WESLEY</u>
Surname: <u>PHILLIPS</u>	Male/Female: <u>MALE</u>	
Date of Birth: <u>05/02/82</u>	Age: <u>23YRS</u>	
Address: <u>45 PROSPECTHILL COURT</u>	Telephone:	
<u>GREENOCK</u>	Marital Status: <u>SINGLE</u>	
Postcode:	Occupation: <u>UNEMPLOYED</u>	
Religion: <u>PRCT</u>	National Insurance No:	
Medical Practitioner & Nurse Details		Consultant: <u>DR ANDERSON</u>
GP's Name: <u>DR MUTCH</u>	Named Nurse/Keyworker: <u>ALAN KERR</u>	
GP's Address: <u>DUBBS PLACE</u>	Associate Nurse:	
<u>PORT GLASGOW</u>	Community Contact:	
GP's Telephone: <u>01475 745321</u>	Contacts:	
Information to relatives: <u>(Yes/No)</u>	Altern	
Named Person/Nearest relative:	Name	
Relationship:	Relat	
Address:	Addre	
Day Telephone:	Day T	
Evening Telephone:	Event	

Admission Time: <u>04.50HRS</u>	Type: <u>EMERGENCY</u>	Date: <u>29/1/06</u>
---------------------------------	------------------------	----------------------

Physical Description:			
Height: <u>6 FT 3 IN</u>	Weight:	BMI	
Obese	Overweight	Healthy	Underweight
Build: <u>TALL / MEDIUM</u>	Eyes: <u>BLUE</u>		
Hair: <u>DARK BROWN SHORT</u>	Skin Colour: <u>WHITE / FACIAL HAIR</u>		
Distinguishing Marks: <u>TATTOO LT FOREARM</u>	Disabilities: <u>TOURETTE'S SYNDROME</u>		

MHSA Status <u>INFORMAL</u>	
Name of Medical Practitioner	Name of MHO
Section applied	Time:
Date:	Review:

Name of Medical Practitioner	Name of MHO
Section applied	Time:
Date:	Review:

AWIA Status - Fully Capable Yes/No - if No - Certificates applied (tick all appropriate boxes)									
Name of Medical practitioner:					Name(s) of relatives consulted:				
Name(s) of staff consulted:									
Part 3 - S.26		Date		Part 5 - S.47		Date		DWP Appointee:	
Part 4 - S.37		Date		Part 6 - S.57		Date			
Renewal due:	Part 5 - S.47	Date		Date		Date		Date	
	Part 4 - S.37	Date		Date		Date		Date	

Patient's Name: WESLEY PHILLIPS

Chi/Unit No.: 0502823496

Clinical Area: HD2

Nurse's Signature: / [Signature]

NHS Argyll & Clyde
Medical Health Information on Admission / Transfer / 6 Monthly Review

Medical / Nursing / Social History on Admission / Transfer / 6 Monthly Review

Reason for admission

Wesley initially presented via A+E w/ Chest Pain / Panic Attacks later referred to acute Admissions unit as he was voicing suicidal ideation. Patient known to Inverclyde Hospital has diagnosis of Tourettes Syndrome / Borderline Personality Disorder with Deliberate Self harm by overdose and lacerations of Arms. Wesley states he has been feeling suicidal for a 3 mth period which has got worse over past 2 weeks. Had thought about throwing himself out of a window, prior to admission thought about throwing himself in front of a train but took a panic attack. Continues to express ideas of Killing himself. On Thursday 26/1/06 claims to have taken an overdose of Co Codamol tablets and lacerated his lt forearm requiring 5 ~~stitches~~ sutures, 3 of which he has since removed. On admission Alcometer reading of 15 due to 2 vodka drinks taken earlier.

Previous Psychiatric History

Known to Inverclyde Royal diagnosis of Personality Disorder with Self-Harm. Apparently patient is not allowed admission to catchment Hospital despite bed being available and identified on assessment Previous history of recurrent self-harm by overdose and laceration, arms have scar tissue from old wounds.

Alcohol & Drug Misuse, Wesley admits to having previously taken Heroin but denies any current use. No history of Alcohol misuse, admits to drinking once a month, vodka only.

Forensic History Wesley has history of physical aggression and A.A.U. staff confirmed he has trashed day Hospital in Inverclyde was charged with Breach of Peace. No custodial sentence served, no present charges.

Past Medical History Has diagnosis of Tourettes Syndrome neck distended on admission and tension felt
No pain in affected area.

PTO.

Patient's Name:

Wesley Phillips

Chi No./Unit No.:

0502823496

Clinical Area:

Ad 2

Nurse Signature:

Lindsay

NHS Argyll & Clyde
Medical Health Information on Admission / Transfer / 6 Monthly Review

Medical / Nursing / Social History on Admission / Transfer / 6 Monthly Review

Social History Wesley lives with his mother in Greenock, he is unemployed on benefits. His father lives in Barrhead but has no contact with him. 2 brothers both older poor contact eldest living in Port Glasgow no contact and other brother living in Wales. Wesley smokes has no financial problems.

Plan Admit to Ward
 Confirm medication with G.P.
 Assess Mental State
 Refer back to sector Ward.

Medication:

Haloperidol 1.5mg TDS
 Quetiapine 50mg at night
 Mirtazapine 30mg once daily

Allergies:

NONE.

Basic Observation

General

Temp:

Pulse:

B.P.:

Patient's Name: Linda Phillips

Chi No./Unit No.: 3502823496

Clinical Area: Wd 2

Nurse Signature: / [Signature]

NHS Argyll & Clyde

Social / Financial Information

Relevant Financial Information		Details	
Manages Own Finances:	Yes:	No:	
Has Withdrawer – Part 3 AWI – Certificate of Incapacity – S.26	Yes:	No:	
Has Financial Guardian – Part 6 AWI - Certificate of Incapacity – S.57	Yes:	No:	
Has DWP Appointee – Regulation 33 – Certificate of Incapacity	Yes:	No:	
Has Fund Manager – Part 4 AWI – Certificate of Incapacity – S. 37	Yes	No	
Review Dates			
:			
Details of Benefits received:		Benefits/Pension held by:	
D.L.A INCOME SUPPORT		PAID TO PATIENT DIRECT VIA BANK.	
Details of Named Person (if different from above)			

Social Work	
Named Social Worker:	Date Referred:
Reference Number:	Date CCA completed:

Assessing Named Nurse:	
Signed:	Date:

Patient's Name: Hesley Phillips

Clinical Area: HD 2

Chi No./Unit No: 0502823496

Nurses Signature: Thorday

NHS Argyll & Clyde

Contact Details for Health & Social Care Professionals

Discipline (including external)	Name	Address	Telephone/ Contact times	Frequency of attendance
G.P.	DR MUTCH	4 DUBBS PLACE PORT GLASGOW	01475 745321.	

Patient's Name: Lesley Phillips

Chi No./Unit No: 0502823496

Clinical Area: Wd 2

Nurses Signature: L. Lindsay

NHS Argyll and Clyde

Observation Status

Patient's Name: Nesley Phillips

Ward: 2

Hospital: RAH

Consultant: DR ANDERSON

Chi No.: 0502823496

Date: 29/1/06

Time:

Observation Level:

GENERAL

CONSTANT

SPECIAL

Reason:

Relative / Carer Informed?

YES

NO

Patient Informed

YES

NO

Authorised By: A.A.U. Staff on admission

Transferred to Case Notes / Nursing Documentation: Nurses Signature: L. Hurday

Date:

Time:

Observation Level:

GENERAL

CONSTANT

SPECIAL

Reason:

Relative / Carer Informed?

YES

NO

Patient Informed

YES

NO

Authorised By: _____

Transferred to Case Notes / Nursing Documentation: Nurses Signature: _____

Date:

Time:

Observation Level:

GENERAL

CONSTANT

SPECIAL

Reason:

Relative / Carer Informed?

YES

NO

Patient Informed

YES

NO

Authorised By: _____

Transferred to Case Notes / Nursing Documentation: Nurses Signature: _____

Observation Status

Patient's Name: _____

Ward: _____

Hospital: _____

Consultant: _____

Chi No. : _____

Date:	Time:		
Observation Level:	GENERAL	CONSTANT	SPECIAL
Reason:			
Relative / Carer Informed?	YES	NO	
Patient Informed	YES	NO	
Authorised By: _____			
Transferred to Case Notes / Nursing Documentation: Nurses Signature: _____			

Date:	Time:		
Observation Level:	GENERAL	CONSTANT	SPECIAL
Reason:			
Relative / Carer Informed?	YES	NO	
Patient Informed	YES	NO	
Authorised By: _____			
Transferred to Case Notes / Nursing Documentation: Nurses Signature: _____			

Date:	Time:		
Observation Level:	GENERAL	CONSTANT	SPECIAL
Reason:			
Relative / Carer Informed?	YES	NO	
Patient Informed	YES	NO	
Authorised By: _____			
Transferred to Case Notes / Nursing Documentation: Nurses Signature: _____			

NHS Argyll & Clyde

Communication Diary

N.B ANY INFORMATION RECORDED THAT RELATES TO A SPECIFIC IDENTIFIED PROBLEM MUST ALSO BE DOCUMENTED IN RELEVANT PROBLEM EVALUATION SHEET

Date & Time		Signature
29/1/06 6am	Wesley has been introduced to staff on duty, was given some oral fluids. Wesley is finding his neck sore due to tension from Tourettes Syndrome given hot pack and 2 Paracetamol tabs for pain. On General Observation.	
29/1/06 11am	Wesley introduced to staff this morning, appears relaxed, nose mucus, cleaned affected area, and dressing applied. Is relaxed, relaxed and being size about 3cm in length not complaining of pain at time of writing.	I. Lunday
29/1/06 1430	Seen by duty doctor (Dr Murray) in view of neck pain reported last night. Wesley presently not experiencing pain, no tenderness noted, the able to move neck and chin without pain. No muscle relaxant / pain relief required.	
2355	Wesley requested sleeping tablet at 10pm medicare, urged to firstly try to sleep. Approached staff at 11.45pm saying he was unable to sleep, over only prescription obtained from duty Doctor of 5mg Zopiclone Wesley given tablet, effect to be assessed.	I. C. R.
30/1/06 1830hrs	Discussed with and interviewed by Dr. Anderson. Wesley has to be discharged either tonight or tomorrow as soon as he can make arrangements.	M. Bell
30/1/06 1900hrs	To have follow up by GP. Wesley was discharged at 1850hrs in company of father.	V. K. (KERR) S/N V. K. (KERR) S/N

Patient's Name: Wesley Phillips

Chi No./Unit No: 0502823496

Clinical Area: Nd 2

NHS Argyll & Clyde
Accountability Record for Care Given (Hospital)

ADMITTED O.H. 504RS 29/1/06

Date	29/1/06	30/1/06					
Early	A. Lawson	I. COL					
Late shift	I. COL	I. COL					
Night	M. Bell						
Date							
Early							
Late shift							
Night							
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Night							

Patient's Name: Lesley Phillips

Chi No./Unit No: 0502823496

Clinical Area: HD2

**A.C.&H.B. GREATER RENFREWSHIRE DIVISION
ADULT MENTAL HEALTH**

PREPARING FOR DISCHARGE QUESTIONNAIRE

Patient's Name	<i>WESLEY PHILLIPS</i>	WARD:	<i>2</i>
Named Nurse	<i>ALAN KERR</i>	Date:	<i>29/1/06</i>

To help us plan for your discharge, please answer the following questions by ticking YES or NO and return the form to your Named Nurse or Depute.

Would you like assistance from an independent advocate?	YES ☐	NO ☒
Do you have any housing /accommodation issues likely to affect your discharge?	YES ☐	NO ☒
Do you have any financial difficulties that may be likely to affect your discharge?	YES ☐	NO ☐
Did you have any of the following services prior to admission to hospital that will need to be informed when you are discharged?		
Home Help	YES ☐	NO ☒
Community Psychiatric Nurse	YES ☐	NO ☒
Care Resource and Support Team	YES ☐	NO ☒
Social Worker	YES ☐	NO ☒
Community Mental Health Team	YES ☐	NO ☒
Do you have any unresolved physical issues that may affect your discharge?	YES ☐	NO ☒
Would you like information about what you could become involved with when you are at home?	YES ☐	NO ☒
Do you have a carer that you would like to be involved in planning your discharge?	YES ☐	NO ☒
Do you have any other issues that may affect your discharge?	YES ☐	NO ☒

PROBLEM SUMMARY SHEET

Clinical Area: NO 2

Focus of Patient Care **NURSING**[illegible]

Individual's Signature: _____ Signed: _____

(Please rule through discontinued plans)

NHS ARGYLL & CLYDE

Focus of Patient Care **NURSING**

Problem No:

Date & Time	Actions/Interventions	Review Date
29/1/06 11.5-4.50am	1) To introduce Wesley to named nurse and associate team nursing staff.	72hrs then Weekly.
	2) To assess mental state through nursing observation, discussion with Wesley and clinical and nursing reviews.	
	3) To provide a safe environment for Wesley which will reduce the risk of deliberate self-harm	
	4) To complete necessary risk assessment documentation and evaluate outcome.	
	5) Aim to spend a period of time with Wesley on a daily basis which will encourage expression of thoughts and feelings.	
	6) To encourage engagement in ward based activities and group with ward and available community resources.	

NHS Argyll & Clyde
CARE PLAN RECORDING / EVALUATION SHEET

Problem No: 1

[illegible]

Patient's Name: Wesley Phillips

Chi No./Unit No: 0502823496

Clinical Area: WD2

Named Professional Signature: L. Lindsay

Date Care Plan Discontinued: _____
Signed: _____

Named Nurse: ALAN KERR

Associate Nurse:

Acute Admissions Unit

Core Treatment Plan for WESLEY 's* wishes & preferences whilst in Hospital

Name: WESLEY PHILLIPS

Chi. No: 0502823496

Ward: 2

PROBLEM No. 2

Date	Identified Need	Review Dates
29/1/06	(Please list) ➤ NO SPECIFIC PREFERENCES ON ADMISSION ➤ ➤ ➤	7 hrs then weekly
Aim/Goal/Objective		
To ensure <u>Wesley</u> * is given the opportunity to express needs/preferences/wishes. And for him/her* to feel that these needs/wishes are valued by the Multidisciplinary Team. For all Team members to endeavour to meet (within reason and practicability) appropriate wishes and preferences.		
Interventions/Actions		
1) <u>Wesley</u> * to inform nursing staff of preferences/wishes and list these as part of the treatment plan. 2) To discuss these with named nurse/associate nurse each week at care review to help ascertain any problems and discuss appropriate ways of dealing with these. Provide support, reassurance, guidance and explanations where and when appropriate. 3) Named/Associate Nurse to liaise with all member so the Multidisciplinary Team to facilitate meeting <u>WESLEY</u> 's* wishes and document this information in the communication diary sheet or evaluation sheet. 4) 5) 6) 7)		

Signature of Nurse: T. LINDOAY

Signature of patient:

Date: 29/1/06

Date:

(* = insert patient's name in blank areas or relevant information)

NHS Argyll & Clyde

CARE PLAN RECORDING / EVALUATION SHEET

Problem No: 2

[illegible]

Patient's Name: Wesley Phillips

Chi No./Unit No: 0502823496

Clinical Area: NA2

Named Professional Signature: J. Lindsay

Date Care Plan Discontinued: _____
Signed: _____

Named Nurse: ALAN KERR

Associate Nurse:

Acute Admissions Unit



Core Treatment Plan for Prescribed Medication

Name: WESLEY PHILLIPS

Chi. No:

0502823496

Ward: 2

PROBLEM No. 3

Date	Identified Need	Review Dates
29/1/06	<u>Wesley</u> * is currently prescribed :- • Anti-psychotic/neuroleptic medication • Antidepressant medication • Anti-cholinergic medication • Mood stabilizer • Anxiolytic • Hypnotic • Sedative {Please circle appropriate, prescribed medication group(s)} Medication Prescribed: _____ _____ _____ Potential Risk of developing the following side effects/problems: AS PER B.N.F GUIDELINES.	72hrs then Weekly
	Aim/Goal/Objective	
	For <u>Wesley</u> * to take prescribed medication and to be provided with information and education regarding medication. To ensure he/she* is aware of the potential side effects and problems and to be able to recognise these and deal with these appropriately. To attempt to minimise and contain side effects which could be attributed to prescribed medication.	

{* = insert patients name in blank area or indicate relevant information.}

Date	Interventions/Actions	Review Dates
29/1/06	1) Administer prescribed medication. 2) Observe for effect and side effect and discuss with <u>WESLEY</u> * and record this information in the Communication diary or evaluation section of the documentation. 3) Complete appropriate side effect assessment tool _____ &/or discuss side effects in full weekly, at each care review by named/associate nurse, ensure this information and any interventions are documented. Inform medical staff also. 4) Provide on-going information giving, education, support and guidance regarding prescribed medications. 5) 6) 7) 8) 9) 10) 12) (Insert further prescribed interventions as and when required)	72 HRS THEN WEEKLY.

Signature of Nurse:

J. Hindray

Signature of Patient:

Date:

29/1/06

Date:

(* = please insert patient's name in blank areas or any relevant information ie: side effect assessment tool, specific medication)

NHS Argyll & Clyde
CARE PLAN RECORDING / EVALUATION SHEET

Problem No: 3

[illegible]

Patient's Name: WESLEY PHILLIPS

Chi No./Unit No: 0502823496

Clinical Area: 1502

Named Professional Signature: L. Horday

Date Care Plan Discontinued: _____
Signed: _____

Named Nurse: ALAN KERR

Associate Nurse:

Acute Admissions Unit



Core Treatment Plan for Patient's Family/Carer Involvement

Name: WESLEY PHILLIPS

Chi. No:

Ward: 2

PROBLEM No. 4

0502823496

Date	Identified Need	Review Dates
29/1/06	<u>WESLEY</u> * has been admitted to hospital for treatment of a Mental Health Problem. Family/carers may require support/reassurance &/or guidance during the period of admission. Family/carers may feel isolated/angry/confused/frightened. They may be unaware of the nature of the various types of mental ill health. They may be unaware of the various services on offer which could be beneficial to them and <u>WESLEY</u> *	<u>22hr</u> <u>then</u> <u>Weekly</u>
	Aim/Goal/Objective To provide support for <u>WESLEY</u> 's* family/carers during the admission period For family/carers to be aware of nursing staff's availability to provide information and education about the various aspects of Mental Health Problems to enable a better understanding and facilitate family/carers involvement in treatment plan. Family/carers to be aware of all the services available to them to provide help/assistance and support during this time and to be aware of who to contact regarding the various aspects of <u>WESLEY</u> 's* care. Family/carers to be aware of the Patient Advocacy Service.	
	Interventions/Actions ➤ Discuss with patient consent to involve family/carers in treatment plan and the divulging of confidential information. Consent Given: NO or YES (circle appropriate response) ➤ Named Nurse/Associate Nurse/other members of nursing staff to introduce themselves to Family/Carers. ➤ Explain Named Nurse System and give contact details regarding named nurse and associate nurse. ➤ Advise family/carers of Consultant and SHO and explain system of contact for medical staff if wishing to discuss any aspect of medical care. ➤ Offer copies of relevant information booklets.	
	If <u>WESLEY</u> * has not consented to allow family/carers to be involved in care and be informed of any confidential issues relating to care the following apply: Explain issues of consent and patient confidentiality to family/carers. Ensure that family/carers are aware of nursing staff's availability to discuss any general questions regarding mental health issues, the Acute Admissions unit, Other agencies, Advocacy etc but that staff cannot discuss anything pertaining to <u>WESLEY</u> 's* care whilst in hospital. Review the consent issue with <u>WESLEY</u> on a regular basis at each care plan review and record results in nursing documentation and ensure all nursing staff are aware of this decision.	Review Date: YES or NO Review Date: YES or NO Review Date: YES or NO

Problem No: 4

Patient's Name: Nerley Phillips

Chi No./Unit No: 0502823496

Clinical Area: *4d2*

Named Professional Signature: /Kundoo

Date Care Plan Discontinued: _____
Signed: _____

**NHS Argyll & Clyde
Assessment checklist**

	Assessment tool	Date	Signature	Review date	Signature
	MANDATORY ASSESSMENTS				
1.	Activity of Living Assessment Day Night -	29/1/06	I. Lindsay		
2.	Moving & Handling	29/1/06	I. Lindsay		
3.	Modified Sainsbury Assessment Level 1	29/1/06	I. Lindsay		
4.	CareNap core + Mental Health component for SSA (As part of Discharge Plan)				
5.	AWI Checklist				
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.	FURTHER ASSESSMENTS				
16.	Modified Sainsbury Assessment – Level 2				
17.	Beck Rating Scale Anxiety/Depression Combined Scale				
18.	Anti psychotic side effect monitoring Lunsers May be completed for patients prescribed anti psychotic medication				
19.	R.E.P.D.S				
20.	Modified Overt Aggression Scale				
21.	Annual Health Screening				
22.					
23.					
24.					
25.					
26.					
27.					
28.					
29.					
30.					

Patient's Name: NESLEY PHILLIPS

Chi No./Unit No: 0502823496

Clinical Area: MD2

NHS Argyll & Clyde
Medical/Health Information on Admission/ 6 Monthly Assessment Summary

Care summary: To be updated as often as necessary – no less than 6 monthly.

Date & Time:		Completed by		
Review date :		Signature		
Communicating	Orientated to time/place Yes/No	Has Glasses? For reading Y/N For Distance Y/N Has Contact lenses Y/N	Has Hearing Aid? Left ear Y/N Right ear Y/N	Can use Nurse Call System? Yes/No
Has speech Yes/No				
Can Hear Yes/No				
Can See Yes/No				
Eating & Drinking		Detail Assistance if Required		
Own teeth Yes/No	Eats & Drinks without assistance? Yes/No			
Upper denture Y/N				
Lower Denture Y/N				
No teeth Y/N				
Eliminating				
Continent of urine Y/N	Goes to toilet without prompting Y/N	Uses toilet independently if prompted regularly? Y/N Uses toilet if taken regularly? Y/N	Requires aids Y/N Specify type.....	Requires assistance with hygiene after using toilet? Y/N
Continent of faeces Y/N				
Mobilising				
Can walk unassisted Y/N	M & H assessment updated? Y/N	Requires assistance of mobility aids Y/N Hoist from bed to chair Y/N Hoist from chair to toilet Y/N Other.....	Requires assisted bath Y/N Assisted shower Y/N	Requires assistance to change position in bed Y/N Specify
Walks with stick(s) Y/N				
Walks with frame Y/N				
Walks with ___nurses Y/N				
In wheelchair/bed Y/N				
Personal Care	If No: Detail Interventions Required		Social/Recreational needs	
Washes unassisted Y/N			Occupies self with hobbies Y/N	
Chooses own clothes Y/N			Activities assessment updated Y/N	
Cleans teeth Y/N			Participates in small groups Y/N	
Brushes/combs hair Y/N			Requires prompting/intervention to meet social needs Y/N	
Breathing			Tobacco use	
Can breathe without difficulty Y/N	Peak flow assessment updated Y/N	Requires inhaler Y/N Requires nebulised oxygen Y/N	Smokes cigarettes/pipe Y/N Requires prompting &/or supervision to use ashtray/lighter/matches safely Y/N	
Can maintain upright posture Y/N				

Patient's Name: Wesley Phillips

Chi No./Unit No: 0502823496

Clinical Area: WD2

Nurse Signature: _____

NHS Argyll & Clyde Investigations/Special Tests Recording Sheet

N.B ALL RESULTS/INVESTIGATIONS SHOULD ALSO BE RECORDED IN IDENTIFIED PROBLEM SHEET

[illegible]

Patient's Name: Wesley Phillips

Chi No./Unit No: 1502823496

Clinical Area: AD2

NHS Argyll & Clyde
Activity of Living Assessment

Patient's Name: Wesley Phillips

Chi No./Unit No: 0602823496

Clinical Area: ND2

1	Maintaining a safe Environment	E.g. Can recognise/remove self from danger, avoid accidents, understands road safety, bedrails required, etc? Can recognise environmental dangers Has history of Self Harm	
2	Communication	E.g. Hearing, Vision Speech? Can communicate needs	Preferred name: <u>Wesley</u> Requires newspaper?
3	Breathing	No Known Respiratory problems	
4	Elimination	Fully Continent	
5	Personal Cleansing	May require further assessment Appears unkempt	Preferences e.g. shower/ bath, un - perfumed toiletries
6	Dressing/ Undressing	Can dress independantly Clothes dirty on admission	Preferences
7	Controlling body temperature	Able to regulate own body temperature to choice, climate & environment.	
8	Mobility	Fully Ambulant.	

NHS Argyll & Clyde

Activity of Living Assessment

9	Activities - Structured - Leisure		Hobbies/special interest
10	Sleep	No Insomnia, no early morning waking reported.	
11	Palliative Care	e.g. Pain Control No pain in neck area.	
12	Mood/ Personality	Mood Low voicing suicidal ideas, no plan.	
13	Orientation - Ability to make choices & decisions	Orientated to time, place & person	
14	Challenging Behaviour (Including Self Harm Behaviour)	Previous history of aggression, trashed day Centre in Inverclyde and had to be evicted from premises	
15	Religion	e.g. Cultural needs, accessing spiritual support, death? Prot.	
16	Nutrition	Likes/dislikes Normal Diet	
17	Drugs/Alcohol	Previous Heroin use, denies any recent use drinks vodka once a month	
18	Hallucinations, Perceptual/ Disturbances, Delusions, Thought Disorders	None	

Date of Assessment: 29/1/06

Review Date: _____

Review Date: _____

Nurses Signature: I Lindsay

PATIENT CARE PLAN

MOVING AND HANDLING SECTION



Person Assessed: <u>WESLEY PHILLIPS</u>		Date of Birth: <u>05/02/82</u>	
Diagnosis:	Assessor: <u>L. Liddon</u>	Date: <u>29/1/06</u>	
Ability to Assist			
		Rating (Please tick)	
Weight Bearing	0	☒	
Partial Weight Bearing	3		
Non Weight Bearing*	4		
Immobile*	5		
Onset of Pain			
No Pain	0		
Minimal Pain	1	☒	
Moderate Pain	2		
Constant Pain	3		
Physical Constraints (If more than one tick highest)			
None	0	☒	
Limb Weakness	2		
Deformity	4		
Extensor Spasm	4		
Behaviour			
Compliance	0	☒	
Partial Compliance	1		
Partial Resistance	2		
Resistance	3		
Weight			
1-5 stones (0-32 kg)	1		
5-8 stones (32-51 kg)	2		
8-10 stones (52-64 kg)	3		
over 10 stones (65 kg)	4	☒	
Score		<u>5</u>	
Date		<u>29/1/06</u>	
Assessor		<u>L. Liddon</u>	
Risk Level	0-4 Low	<u>5-10 Medium</u>	11+ High
High Risk	Use of Hoist Recommended		
Medium Risk	Hoist / Handling Equipment May be Required		
*Hoist must be used at all times			

PATIENT CARE PLAN

METHODS OF MOVING AND HANDLING

Into Bath or Shower

Handling Aid		Which Bath		Supervision of Patient		Patient Independent	☒	No Bath or Shower	
Ambulift		Parker		People	1	2	Additional Information:		
Dextra		Var Height							
Shower Chair		Standard							
Other		Other							

Transfers (Including to / from: bed: wheelchair)

Hoist		Manual Support		Instructions to Patient		Supervision of Patient		Patient Independent	☒
People	1	2	3	People	1	2	Additional Information:		
Dextra									
Oxford									
Standard (Sara)									
Other									

Toileting (Includes on/off bedpan)

Hoist		Manual Support		Instructions to Patient		Supervision of Patient		Patient Independent	☒
People	1	2	3	People	1	2	Additional Information:		
Dextra									
Oxford									
Standard (Sara)									
Other									

Moving up / down bed

Hoist		Handling Aids		Manual Support		Instructions to Patient		Comments
People	1	2	3	People	1	2	3	Supervision of Patient Patient Independent ☒
Dextra		Blue Sling						
Oxford		Slide Sheet						
Other		Hand Block						
		Other						

Sit up over side of bed

Hoist		Handling Aids		Manual Support		Instructions to Patient		Comments
People	1	2	3	People	1	2	3	Supervision of Patient Patient Independent ☒
Dextra		Rope Ladder						
Oxford		Slide Sheet						
		Other						

Other Instructions:

Continue on additional sheet if necessary

Assessors signature: L. Lindsay

Date Assessed: 29/1/06 Proposed Review Dates:

Mental Health & Learning Disabilities

Source: Sainsbury Centre for Mental Health

RISK ASSESSMENT AND MANAGEMENT (LEVEL 1)

Alcometer
15

CLIENT NAME: Wesley Phillips D.O.B.: 29/01/1980 ID No:

ADDRESS: 45 Prospect Hill Court Greenock POSTCODE:

DATE/PERIOD OF ASSESSMENT: 29/01/06 TIME: 01:30 REVIEW DATE: 1/1

RISK FROM OTHERS (eg. Abuse, exploitation)

YES ☒ NO ☐ UNKNOWN

Details of identified risk:

Further investigation required*

RISK TO SELF (eg. Suicide, self harm)

YES ☒ NO ☐ UNKNOWN

Details of identified risk:

States long history of self harm including
O/D - cutting self. States 3 month history of suicidal
thoughts, numerous plans stated. In full recovery.

Further investigation required*

RISK TO OTHERS (eg. Aggression, violence)

YES ☒ NO ☐ UNKNOWN

Details of identified risk:

STATES POLICE RECORD OF B.O.P. DOES
ASSAULT & PRISON SENTENCE. NOTES STATE POLICE ASSAULT
charges & 1 PRISON TERM (Previous Assessment). STATES NO
ongoing charges or Court cases.

Further investigation required*

RISK OF NEGLECT (eg. Health, personal)

YES ☒ NO ☐ UNKNOWN

Details of identified risk:

States No motivation for Personal Hygiene

Further investigation required*

RISK TO CHILD(REN) (eg. Neglect, abuse)

YES ☒ NO ☐ UNKNOWN

Details of identified risk:

Further investigation required*

RISK OF PHYSICAL IMPAIRMENT (eg. Medical, sensory)

YES ☒ NO ☐ UNKNOWN

Details of identified risk:

Complaining of Neck Spasm / Pain

Further investigation required*

RISK OF WANDERING and/or FALLS

YES ☒ NO ☐ UNKNOWN

Details of identified risk:

Further investigation required*

MEMORY & COGNITIVE IMPAIRMENT

YES ☒ NO ☐ UNKNOWN

(eg. Forgetfulness)

Details of identified risk:

STATES HAS VERY POOR
CONCENTRATION OVER LAST 2/52

Further investigation required*

CHALLENGES TO SERVICES

YES ☒ NO ☐ UNKNOWN

(eg. Inappropriate demands, poor service response)

Details of identified risk:

Presenting out of Catchment area.

Further investigation required*

SIGNIFICANT KNOWN HISTORY (including known diagnoses):

Diagnosed Tourette's syndrome when 15, has had contact with Inverclyde Services. UNDER care of Dr. Howden. Had wanted Day Centre though is now barred due to destructive behaviour.

INITIAL ASSESSMENT OF RISK (including context, situations in which risks may

occur):

History of impulsive behaviour. Many episodes of self harm. Expresses ongoing thoughts of killing self - plans to throw them self out window or in front of train.

INITIAL RISK MANAGEMENT PLAN (including who is to do what):

FOR OBSERVATION OF MENTAL STATE.
ADMIT - Contact Inverclyde Royal Hospital as their catchment area - 13ed manager states bail is available. Inverclyde Hospital Refused Admission - See Special Complaint.
ADMIT WD 2 R.A.U. General OBS.

SOURCES OF INFORMATION: AVAILABLE

Wesley, Case Notes.

CONTEXT OF CLIENT FOR ASSESSMENT

ROLE OF CLIENT and/or CARER IN PLAN:

CLIENT INVOLVED: ☒ YES / NO

CARER INVOLVED: YES / NO

CLIENT AGREED: ☒ YES / NO

CARER AGREED: YES / NO

COMMENTS:

NEED FOR RISK ASSESSMENT & MANAGEMENT (LEVEL 2) YES / NO

Recorded by:

[Signature]

Date: 29/1/05

Discussed with:

[Signature]

Time: 3pm

N.B.:—A NEW RECORDING SHEET MUST BE TAKEN EACH TIME
A PRESCRIPTION SHEET IS CHANGED.
PRESCRIPTION SHEET No.:-

KEY
Ⓐ DRUG REFUSED
★ PATIENT ABSENT

DRUG RECORDING SHEET

Date	REGULAR PRESCRIPTIONS						DEPOT INJECTIONS		AS REQUIRED PRESCRIPTIONS			COMMENTS ON DISCREPANCIES	
	8 a.m.	1 p.m.	6 p.m.	10 p.m.	OTHER TIMES		Code	Sig.	Code	Time	Sig.		
29/1/86	Code	Code	Code	Code	Code	Code			Code	U	Code	U	u. prescribed by u. by hand
	Sig.	Sig.	Sig.	Sig.	Time	Time			Time	4.45	Time	4.10	
	Sig.	Sig.	Sig.	Sig.	Sig.	Sig.			Sig.	4.45	Sig.	4.10	
	Code	Code	Code	Code	Code	Code			Code		Code		
	Sig.	Sig.	Sig.	Sig.	Time	Time			Time		Time		
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N.B.:— A NEW RECORDING SHEET MUST BE TAKEN EACH TIME
A PRESCRIPTION SHEET IS CHANGED.
PRESCRIPTION SHEET No.:-

KEY	
(A)	DRUG REFUSED
X	PATIENT ABSENT

DRUG RECORDING SHEET

Date	REGULAR PRESCRIPTIONS						DEPOT INJECTIONS		AS REQUIRED PRESCRIPTIONS			COMMENTS ON DISCREPANCIES
	8 a.m.	1 p.m.	6 p.m.	10 p.m.	OTHER TIMES		Code	Sig.				
	Code	Code	Code	Code	Code	Code			Code	Code	Code	
	Sig.	Sig.	Sig.	Sig.	Time	Time			Time	Time	Time	
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	Sig.	Sig.	Sig.	Sig.	Time	Time			Time	Time	Time	
	Sig.	Sig.	Sig.	Sig.	Sig.	Sig.			Sig.	Sig.	Sig.	

Wesley Phillips

NAME OF PATIENT

AGE/DOB 05/02/82 23 UNIT No.

CONSULTANT

WARD

	START DATE	REGULAR PRESCRIPTIONS			Tick if Before Meals	DRUG ROUNDS				Other Times		PRESCRIBER'S SIGNATURE	PHARMACIST	DISCONTINUED	
		DRUG (Block Letters: Generic Name)	DOSE	ROUTE		8 am	1 pm	6 pm	10 pm					DATE	INITIALS
A															
B															
C															
D															
E															
F															
G															
H															
I															
J															
K															
L															
M															
N															
O															
P															
Q															
		DEPOT INJECTIONS		DOSE	FREQUENCY										
R															
S															
T															
		AS REQUIRED PRESCRIPTIONS	DOSE	ROUTE	INDICATION	MAXIMUM FREQUENCY									
U	29/1/06	APPROVED LIST	At	PER	PROTOCOL										
V															
W															
X															
Y															
Z															

ONCE ONLY						TICK IF PRESCR. ON FOLLOWING SHEETS		LIST OF DRUGS TO BE AVOIDED DUE TO PREVIOUS REACTION	
DATE	DRUG (Block Letters)	DOSE	ROUTE	TIME	SIGNATURE	GIVEN BY	Given at		
29/1/06	ZOPICLONE	7.5mg	O	23:50	REL PRESCRIPTION DE AMILUON	M. Bell	23:55	Diet	
								Anticoagulant	
								Insulin	
								Fluid	
								Chlormethiazole	

NAME OF PATIENT

WESLEY PHILLIPS

PRESCRIPTION SHEET (PSYCHIATRIC)

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STY0434D

SHEET No.