

**Glasgow City
Community Health Partnership
North East Sector**

Anvil Mental Health Resource Centre
81 Salamanca Street
Glasgow
G31 5ES
Tel: 0141 211 8480
Fax: 0141 211 8474



CONFIDENTIAL

Dr Johnstone
Barony Practice
Northcroft Medical Centre
Northcroft Street
Paisley
PA3 4AD

Date: 28-Sep-15
Your Ref:
Our Ref: SM/AL

Dear Dr Johnstone,

WESLEY PHILLIPS, CHI: 0502823496
Flat 0/1, 51 Thrushcraig Crescent, Paisley, PA2 6PP

DATE OF ADMISSION: 24/12/13

DATE OF DISCHARGE: 27/12/13

DIAGNOSIS: Borderline Personality Disorder with Dissocial Traits

LEGAL STATUS: Informal

MEDICATION ON DISCHARGE: Methadone 50ml od, Sertraline 150mg od

Welsey was admitted to Ward 3, Parkhead Hospital, Glasgow on 24th December, 2013 after presenting to A & E at Glasgow Royal Infirmary complaining of suicidal ideation. He has a history of Borderline personality Disorder, ex-intravenous drug use and low mood. He stated that his mood had dipped over the previous few weeks. It appeared that he had fallen out with his brother and father due to gambling away his benefits, despite owing them money. It seems that this had triggered his suicidal thoughts.

In addition, he stated that he had separated from his girlfriend a few months previously and that it was approaching the anniversary of his mother's death, which is always a difficult time of year for him.

On admission, he did not appear overtly depressed and had a reactive affect at interview. He stated that he was hearing voices, but that this had been "going on for years". He claimed these voices were saying "you've let your family down" and "you've nothing to live for". He stated that in response to this he had tried to throw himself in front of a taxi and that the driver of the taxi had driven him to A & E. He was adamant that if he was not admitted to hospital he would find a way to kill himself that night. He lives alone and was socially isolated due to falling out with his family.

There was no evidence of any psychotic symptoms on the ward and it was thought the voices that he complained of were not true auditory hallucinations. He denied any ongoing suicidal thoughts and was therefore discharged on 27th December, 2013 with follow-up from the Intensive Home Therapy Team in Paisley. No follow-up at Parkhead Hospital has been arranged.

Please do not hesitate to contact me if you have any questions.

Yours sincerely,

Dr Scott Mackenzie
GPST2 to Jacqueline Anderson
CONSULTANT PSYCHIATRIST
c.c. Dr McMahon
Renfrewshire Drug Service
Back Sneddon Centre
Paisley, PA3 2DJ,



Renfrewshire
Community Health Partnership

Paisley Community Mental Health Team
The Charleston Centre
49 Neilston Road
Paisley PA2 6LY



Telephone: 0141 618 5600

Date: 20/11/2014
Dictated: 12/11/2014
CHI: 0502823496
PIMS: 1808520
Ref: SS/LM

PRIVATE AND CONFIDENTIAL

Dr Johnstone
Barony Practice
Northcroft Medical Centre
Northcroft Street
Paisley
PA3 4AD

Dear Dr Johnstone

RE: Wesley Phillips (05/02/1982) 0/2, 51 Thrushcraig Crescent, Paisley, PA2 6PP

Following a referral from IHTT I offered the above patient his initial appointment in 12th November 2014. Unfortunately he failed to attend this appointment. Later on in the day he called to state that he had forgot about his appointment and requested another appointment. I have sent him another appointment for 10th December 2014 at 9.30am at Dykebar Hospital hoping that he will engage with the service.

Yours sincerely

Dr S Shanmugam
Specialty Doctor in Psychiatry



Renfrewshire
Community Health Partnership

Paisley Community Mental Health Team
The Charleston Centre
49 Neilston Road
Paisley PA2 6LY

Telephone: 0141 618 5600



Date: 29/10/2014
Dictated: 29/10/2014
CHI: 0502823496
PIMS: 1808520
Ref: SS/LM

PRIVATE AND CONFIDENTIAL

Mr W Phillips
0/2, 51 Thrushcraig Crescent
Paisley
PA2 6PP

Dear Mr Phillips

Following referral from your GP I would like to offer you an appointment to meet with me on:

Wednesday 12th November 2014 at 9.30am at Hollybush Out Patient Department, Dykebar Hospital

If this is unsuitable please contact the office as soon as possible and another appointment can be arranged.

Yours sincerely

Dr S Shanmugam
Specialty Doctor in Psychiatry

[Faint, illegible text, possibly a signature or stamp]



Date: 27th October 2014
Dictated: 26th October 2014
CHI: 0502823496
Ref: EMcG/SC

PRIVATE & CONFIDENTIAL

Dr Johnston
Barony Medical Practice
Northcroft Medical Centre
Paisley
PA3 4AD

file copy.

Dear Dr Johnston

RE: Wesley Phillips, Flat 0/2, 51 Thrushcraigs Crescent, Paisley
Date of Birth: 05.02.82 (3496)

The above named gentleman was referred to the Intensive Home Treatment Team for psychiatric assessment by staff at Ward 10, R.A.H. and was reviewed by myself and Senior Practitioner, Brian Gibson as Mr Phillips had been admitted in early hours of 24.10.14 following an overdose of heroin and paracetamol tablets. As you may be aware Mr Phillips has a diagnosis of borderline personality disorder and poly substance misuse and has attended the R.A.H. on multiple occasions in the past in similar circumstances.

At assessment today Mr Phillips reported a deterioration in his mood over the past several weeks. He feels this has been precipitated due to his lifestyle choices and although purporting that he has remained abstinent from drugs, he seems to have swapped one addiction for another, spending most of his time and money on gambling machines at the local bookmakers. Mr Phillips advised that he is no longer involved with Renfrewshire Drug Services as he is no longer on Methadone programme and has been abstinent from illicit substances until the overdose of heroin on 24.10.14. He did state that this overdose was not an intent to kill himself, however was more a cry for help as he has become increasingly isolated and detached from psychiatric services and feels he is wasting his life gambling. Mr Phillips reported no residual suicidal thoughts, plan or intent. Indeed he was keen on the offer of referral to RAMH services to provide some structure and routine in his life which he acknowledges is sadly lacking.

Following discussion with On Call Spr for South Glasgow, Dr Gilkes it was agreed that referral to Out Patient services for psychiatry would be appropriate in the circumstances given his current medication regime of Aripiprazole 5mgs and Sertraline 150mgs which his use of has been inconsistent in the last few weeks. Mr Phillips did contract to safety and was keen to return home and looking forward to engaging with services discussed. During assessment Mr Phillips engaged well with staff. He spoke clearly and there was no evidence of any formal thought disorder, paranoia or delusional ideation. He did purport to experiencing auditory hallucinations though these seem to be in the context of his low mood and it was difficult to distinguish whether these were thoughts or voices. His cognition was grossly intact and he retained insight. Should you require any further information please do not hesitate to contact the team on the above telephone number.

Yours sincerely

Eddie McGee
Intensive Home Treatment Practitioner
Intensive Home Treatment Team

REFERRALS FROM SCREENING – PENDING/TRACKING/OUTCOME

Name	Wesley Phillips																	
CHI	0	5	0	2	8	2	3	4	9	6	PIMS	1	8	0	8	5	2	0

DATE	ACTION	BY WHOM	OUTCOME
			12/11/2014
			9.30 Dykoba OR

URGENT ☒ **ROUTINE** ☐

Disciplines Attending:- Medic ☐ Psychology ☐ Health ☒ Social Work ☐

Date of Outcome Decision:- 27 / 10 / 14

Internal

Psychology - Assessment ☐ Treatment ☐

Psychiatry ☒

Team Assessment

- Clinic ☐
- Home ☐
- Opt-in ☐
- Duty Hub ☐

Dr. Shannugam

App Date/Time -
Worker(s) -

Team Waiting List

Priority

P

- CPN ☐
- Generic ☐
- OT ☐
- Social Work ☐

External

CDS ☐
Doing Well ☐
RAMH ☐
Other ☐

Relevant Information/Reasons for Decision

P12

REFERRAL

What Service/Discipline is referral for:	Medical Psychiatry		
Date Assessed:	25.10.14	Time of Assessment:	12.30

Personal Details			
Surname:	phillips	CHI Number:	0502823496
Forename:	wesley	Relationship Status:	single
Dob:	05.02.82	Age:	32
E-Mail Address:		Referral Urgency:	Urgent
Registered GP:	johnstone Barony M.P	Practice Code:	
Patients Address:	0/2 51 Thrushcraigs Cres	Sex:	Male
		Telephone No:	
Post Code:	pa2 6pp	Mobile No:	07847292196

Additional Information		
Children: No	At Home: No	SW Involvement: No
Risk Factors:	Other (Please state) Forensic History assaults.	
Consent to Referral:	Patient is aware of referral	Has a Glasgow Risk Assessment Been Completed:Yes
Involved Parties:	Other (please specify)	
Disabilites:	Mobility No issues	
Brief History/Current Issues:	Diagnosis Borderline personality disorder .. Mood variation Polysubstance abuse..previously known to RDS..no longer on methadone programme. Social isolation...low mood....Gambling addiction	

RECEIVED 27 OCT 2014

Reason for Referral:

Patient consented to emergency psychiatric assessment following admission via A& E TO WD 10 in the early hours of 24/10/14. Reporting suicidal ideation overdose of paracetamol and heroin.

States lowered mood increasing isolation and withdrawal since release from Low Moss prison Sept 14, (shoplifting/assault) 6 month sentence.

States imprisonment allowed him to reduce and stop his methadone. Claiming he is drug free and has been discharged from RDS.

Use of heroin leading to admission was first since release and an attempt to end his life.

Current medication Sertraline 150 mgs and Aripiprazole 5mgs being managed by GP though he rarely sees GP for consultation getting repeat prescriptions which he admits to poor concordance with due to lack of routine and structure in his lifestyle.

Suffering from auditory hallucinations good and evil voices making derogatory comments urging him to "end it" as he has wasted his life.

Currently reporting he has exchanged one addiction for another now gambling daily at bookies losing all his money on gaming machines.

States overdose was not full attempt to end his life...retains insight...more a cry for help from services. Following discussion with on-call SPR.

Contracted to safety and referral to outpatients for medical review, and referral to RAM-H for involvement in the active programme.

Information provided for gamblers anonymous and crisis numbers

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Referred By: EMCGEE // B. GIBSON
Location: Charleston centre
Designation: IHTT
Contact Information/Number: 618 3333
Date Referred: 26/10/14
Email to: healthrecords.dykebarhospital@ggc.scot.nhs.uk

LIAISON

DR ZILKES

Renfrewshire
Council

EMERGENCY ASSESSMENT REQUEST

IHTT TELEPHONE REFERRAL

Greater Glasgow
and Clyde

Date of Referral: 25/10/14		Time of Referral: 09.55	
Name: WESLEY NARRA PHILLIPS	Sex: M	DOB: 5/2/82	CHI No: 3496
Home Address: FLAT 0/2 51 THEUSHICRAIES CREES		GP: Dr Thubone Address: Burney Practice	
Postcode: PA2 6PP. (Postcodes P1-12& P14 acceptable. P13 excluded)		Telephone No:	
Telephone No:		Next of Kin/Sig Other:	
Mobile:		Relationship:	
Current Location If Different:		Address:	
		Telephone No:	

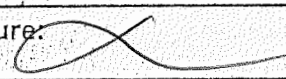
Referrer: Dr Kanya.	Agency: WARD 10	Tel No:
Seen in last 24 hours: YES ☒ NO ☐		
Patient known to psychiatric services: YES ☒ NO ☐ NK ☐		
If yes those involved:		
Legal Status:	CPA (Care Manager):	

Reason for Referral/Current Presentation

Overdose admitted yesterday
lonely
lack routine structure
gambling

Diagnosis:

diagnosis poly substance misuse
personality disorder

Any children at home: YES ☐ NO ☐			
Names:	Gender	D.O.B.	Current location / carer:
History of alcohol abuse: YES ☐ NO ☐ Past ☐ Present ☐ History of drug abuse: YES ☐ NO ☐ Past ☐ Present ☐ 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 ☐ Details: Potentially dangerous to others ☐ CONSIDER ASSESSMENT AT DYKEBAR ☐			
KNOWN FORENSIC HISTORY : YES ☐ NO ☐ Past ☐ Present ☐ Details: Potentially dangerous to others ☐ CONSIDER ASSESSMENT AT DYKEBAR ☐			
KNOWN HISTORY OF SELF HARM : YES ☐ NO ☐ (Overdose / cutting / other)			
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:			
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 Dr: YES ☐ NO ☐ Time:			
Signature: 	Date: 25/10/14	Time: 09.55	

PRIVATE & CONFIDENTIAL

Wesley Phillips
8 Thomson Brae
Paisley
PA1 1TP

Dear Mr Phillips,

Following your assessment with Out Of Hours Service on 04/05/2014.

I.H.T.T. have attempted to contact you unsuccessfully.

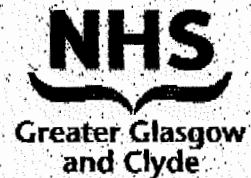
Therefore IHTT would like to offer you an Out Patients appointment at A.A.U. Dykebar Hospital on Monday the 5th of May 2014 at 10am, for further assessment of your needs.

If this is unsuitable, please contact IHTT on the above number.

Yours sincerely

Angela Kelly
Senior Intensive Home Treatment Practitioner
Intensive Home Treatment Team

IHTT



Glasgow City CHP
Mental Health Services

**Out of Hours
CPN Service**

Caledonia House
140 Fifty Pitches' Road
Glasgow
G51 4ED
Tel 0845 650 1730
Fax 0141 616 6259

IHTT

Service Hours Monday to Friday 19.30 – 09.30 Hrs
Weekend / Public Holidays 16.30 – 09.30 Hrs

To	Telephone Number	Fax Number	Sent
PASLEY INTT	618 3333	618 5381	
* Referral.			

From: M. M'CREAGIE

No of Pages: 7 (Inc cover)

Telephone Number 0845 650 1730

Fax Number 0141 616 6259

STRICTLY CONFIDENTIAL FAX

**IF RECEIVED IN ERROR PLEASE DESTROY IMMEDIATELY
AS MATTER OF URGENCY PLEASE TELEPHONE 0141 211 6505
(MON – FRI 09.00 – 17.00HRS) TO NOTIFY ERROR.**

For Out of Hours use only

CMHT / Keyworker Info		Pinned	✓
Desk Duty / K.W Follow up	✓		
Crisis for Follow-up			

Case No 4073273

Case Active 03/05/2014 21:36

Case Type Patient Transport

Patient WESLEY PHILLIPS

Sex M D.O.B 05/02/1982 Age 32 years

Current Address

Home Address (if currently not at home)

8 Thomson Brae

Paisley

PA1 1TP

Current Phone: 07432 134470

Home Phone: 0141 532 6255

Case Origin

Callers Name

Callers Tel:

Own Doctor Johnston, Christopher (A81)

Surgery A 81 The Barony Practice

NHS24 Received By

NHS24 Triage Start

NHS24 Triage By

NHS24 Triage End

NHS24 Reported Condition

NHS24 Recorded Allergies

NHS24 Recorded
Medications

NHS24 Recorded Medical History

NHS24 Clinical Summary

NHS24 Disposition

NHS24 Nurse Comments

Reported Condition Received By TSTEV

Received 21:35

Symptoms: WISHES TO SPEAK TO A CPN PLEASE

TAS Assessment

Assessed By

TAS Assess Start

TAS Assess End

Consultation

Consult By

McCreadie, Maini (CC)

Consult Start

23:48

Consult End

23:49

Cpns returned call to Wesley this evening. Wesley is at a friends house tonight and states that his head has just gone' and that he has 'so many thoughts' that have built up over the past few days. Wesley reports that he is having suicidal thoughts and that he would rob a shop so that the police would shoot him or he would end up in prison. Stopped using heroin 2 days ago but does not believe that there is any correlation between this any how he is feeling. He denies that he is experiencing any withdrawals from heroin other than the psychological effects and suicidal thoughts. States that he last harmed himself 2 months ago when he took paracetamol. Current diagnosis is personality disorder and substance misuse.

Current medications Sertraline and Aripiprazole but does not feel they help.

Spoke about people being out to get him but in the past has been attacked and this appears to be a fear based in reality.

Friend reports that over the past 48 hours he has been sending texts to friends indicating that he plans to kill himself.

Agreed to face to face assessment at RAH gp service and is waiting for a friend to come who will be able to accompany him. Agreed that cpn will contact Wesley back at 11pm to arrange this.

Patient transport to RAH

Examination Details

Clinical Codes

Diagnosis

Case No 4073273

Case Active 03/05/2014 21:36

Case Type Patient Transport

Treatment**Consultation**

Consult By McCreddie, Malin(CC)

Consult Start 01:53

Consult End 02:38

Examination Details

Wesley attended the GP dept at RAH as agreed. He presents as a tall well built man who was dressed appropriately, he appeared well kempt and neat but was malodorous.

Maintained good eye contact throughout but pupils were pinpoint. Speech was normal in tone and rate with content relevant to the subject being discussed.

There was no evidence of any pressure or poverty of speech.

Wesley appeared calm and relaxed during the assessment and rapport was easily established.

Wesley states that for the past week he has felt more unsettled and that he has been using heroin and street diazepam in this time. Initially Wesley stated he had no drugs for the past 2 days, however he then said that he had used 2x £20 bags of heroin he injected this afternoon and also 14 Diazepam tablets which he did not want to tell his friends about. He had pinpoint pupils and admitted that he could still feel the effects of drugs in his system. Currently attends the addiction service and has joined the AA 5 days ago and will be allocated a sponsor this week. He states that his sponsor will be taking him to Denmark as he does talks over there.

Has had periods of sobriety but states they are not for any significant length of time.

Has had prison sentences in the past for robbery. No aggressive or hostile behaviour displayed during assessment.

Has a history of self harm which includes cutting, overdosing walking in front of traffic. States that he last self harmed when he took an overdose of paracetamol 2 months ago. Wesley states that for the past week he has been experiencing suicidal thoughts. He listed a variety of ways he could harm himself when asked about this, however he denied that he had any active plan or intent to kill himself at time of assessment. Wesley was clear that he did not want to die but that sometimes he felt his life was not working out the way he intended.

He denied that there are any triggers or precipitants to how he is feeling at present and denies that there have been any altercations or that anyone is after him. He states that often feels that people may be after him but relates this to his past when he has been attacked. There was no evidence of any paranoid thought processes.

Wesley states that for many years he has heard voices which say he is a failure and no good etc, however these appear to be his own thoughts and not psychotic in nature. He did not appear to be distracted or preoccupied during the assessment and there was no evidence of any thought disorder.

Mood brightened as the assessment progressed and Wesley was smiling and laughing towards the end. States his sleep is poor but that he is tired tonight due to Diazepam use.

Wesley states that in the past he feels that he is always referred back to his addiction team and that this does not deal with any other problems. Explained to Wesley the need for him to be sober to allow any assessment process and he did appear to understand this. He states he has been diagnosed with a borderline personality disorder but did not know what this meant. Briefly explained this and Wesley appeared to identify with some of the things spoken about.

Wesley was keen to go into hospital tonight as he feels secure there, however discussed with him referral to IHTT and then CMHT as it will be longer term work and he was keen for this. He states that he is going back to his friends tonight but is not sure whether he will be able to stay there tonight or will return to his own flat.

Wesley stated that he would be safe overnight and that if this changed he would contact service back again.

Wesley provided cpn with his mobil number for contact by IHTT on Sunday 07847 292 196.

Diagnosis

F1, F6 known to Cat East Ren

Treatment**Clinical Codes**

8.... Other Therapeutic Procedures

Case No 4073273

Case Active 03/05/2014 21:36

Case Type Patient Transport

Will refer to IHIT for further assessment of mental state on Sunday 04/05

Prescriptions

Follow-up(s)

Other -

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



Service Users Name: WESLEY PHILLIPS	Chi No / DoB: 5-2-82	PIMS No:
Legal Status: Informal ☒ Detained ☐ Community Order ☐	Ward / Dept / CMHT: 00N	

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 PIMS, GENISTS	

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 (eg. 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: MAIRI MCCREADIE	Signature: M. McCreadie
Designation: CPN	Date & Time: 4-5-14

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



Suicide &/or Self Harm		Violence		Other Risk 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	☐
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	☐
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 long h/o self harm/parasuicide. Reports suicidal thoughts but no active plan or intent @ time of assessment. - refer to IMTI.	
Violence Has had prison sentences for robbery.	
Other Risk Factors Ongoing heroin abuse - currently attending CAT.	

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: NAIRI MCCREADIE	Signature: M. McCreadie
Designation: CPN	Date & Time: 4-5-14

20 Back Sneddon Street
PAISLEY PA3 2DJ

Our ref: CMCM/KAC/CHI: 0502823496
Date: 15 April 2014
Date Dictated: 08 April 2014

Renfrewshire Drug Service
Direct: 0141-618-2585
Fax: 0141-618-5267

PRIVATE & CONFIDENTIAL

Dr Johnstone
The Barony Practice
Northcroft Medical Centre
Northcroft Street
Paisley PA3 4AD

Dear Dr Johnstone

Wesley Phillips (0502823496)
1-4 17 Abercorn Street, Paisley PA3 4AA

Psychiatric Diagnosis: F11.2 – Opiate Dependence, Adult Personality Disorder

Current Psychotropic Medication: Methadone 50 mls daily supervised, Sertraline 150 mgs, Aripiprazole 5 mgs

I saw Wesley for further review at Renfrewshire Drug Service on 08 April 2014. Wesley looked relatively well today. He had been very unsettled over the Christmas period and had a brief admission to Parkhead hospital and contact with the Intensive Home Treatment Team (IHTT) following suicidal thoughts. He says that the thoughts have continued and that God is telling him to commit suicide. He continues to complain of feeling tense and agitated and unhappy, unmotivated and unsettled. It does seem that he has significantly moderated his drug use. There have been no signs he has been using cocaine and he seems to have been using relatively little Valium and heroin.

His social circumstances remain difficult. He hasn't been speaking to his father for some time. His own flat is in a state of disrepair but it looks like he will have to remain there. He has trouble furnishing it basically because he spent all his money on gambling.

He is constantly asking for tablets to settle his nerves. He has QTc interval problems if Methadone is increased beyond 50 mls. I have decided to try a small dose of Aripiprazole, which does not have any cardiac induction effects, at least on a trial basis. I will let you know how things progress.

Yours sincerely

Dr Charles McMahon
Consultant Psychiatrist

20 Back Sneddon Street
PAISLEY PA3 2DJ

Our ref: CD/KC/CHI: 0502823496
Date: 22 January 2014
Date Dictated: 21 January 2014

Renfrewshire Drug Service
Direct: 0141-618-2585
Fax: 0141-618-5267

PRIVATE & CONFIDENTIAL

Dr Johnstone
The Barony Practice
Northcroft Medical Centre
Northcroft Street
Paisley
PA3 4AD

Dear Dr Johnstone

Wesley Phillips (0502823496)
1-4 17 Abercorn Street, Paisley PA3 4AA

Psychiatric Diagnosis: F11.2 – Opiate Dependence

Current Psychotropic Medication: Methadone 50 mls daily supervised, Sertraline 150 mgs

I reviewed Mr Phillips at Renfrewshire Drug Service on 21 January 2014. He describes to having had an unsettled time over the festive period. To this end he had a short admission to Parkhead hospital and was subsequently supported by the IHTT team. He describes a number of recent stressors including his ex-girlfriend's miscarriage and the anniversary of his mother's death. He believes that these have impacted on his mood over the last month or so. He also described that his sleep regime has not been settled over the past 2 weeks. I note that he is currently residing mainly at his father's house more than at his own flat. He described no ongoing suicidal ideation today. He does however express ideas that his current antidepressant may not be working for him. He has had a recent ECG on 10 December 2013 which demonstrates an elongated QTc interval of 510 m.s. While Mr Phillips suggested tentatively an increase in his medications may be helpful I have explained that changes to his medications may not be effective and indeed may be detrimental in terms of his current ECG.

He does describe ~~he~~ today having used a bag of heroin several days ago, which he injected. He denies the use of anything since this period of time. I have made no changes to his medication and will continue to review him at the drug clinic.

Yours sincerely

Dr Claire Duncan,
ST3 in Addiction Psychiatry

Dr Charles McMahon
Consultant Psychiatrist

Renfrewshire
Community Health Partnership

Paisley Community Mental Health Team
The Charleston Centre
49 Neilston Road
Paisley PA2 6LY

Telephone: 0141 618 5542



Date: 17/02/2014
Dictated: 15/12/2014
CHI: 0502823496
PIMS: 1808520
Ref: SS/LM

PRIVATE AND CONFIDENTIAL

Dr Johnstone
Barony Practice
Northcroft Medical Centre
Northcroft Street
Paisley
PA3 4AD

Dear Dr Johnstone

RE: Wesley Phillips (05/02/1982) 0/2, 51 Thrushcraig Crescent, Paisley, PA2 6PP

I am writing to inform you the above patient had his second initial appointment with myself on 10th December 2014. Unfortunately he failed to attend this appointment and has not contacted the service. At this point I am not offering any further appointment with myself. If there are any concerns please do not hesitate to re-refer him back to our service.

Yours sincerely

Dr S Shanmugam
Specialty Doctor in Psychiatry



Renfrewshire
Community Health Partnership

Paisley Community Mental Health Team
The Charleston Centre
49 Neilston Road
Paisley PA2 6LY

Telephone: 0141 618 5542



Date: 17/02/2014
Dictated: 15/12/2014
CHI: 0502823496
PIMS: 1808520
Ref: SS/LM

PRIVATE AND CONFIDENTIAL

Dr Johnstone
Barony Practice
Northcroft Medical Centre
Northcroft Street
Paisley
PA3 4AD

Dear Dr Johnstone

RE: Wesley Phillips (05/02/1982) 0/2, 51 Thrushcraig Crescent, Paisley, PA2 6PP

I am writing to inform you the above patient had his second initial appointment with myself on 10th December 2014. Unfortunately he failed to attend this appointment and has not contacted the service. At this point I am not offering any further appointment with myself. If there are any concerns please do not hesitate to re-refer him back to our service.

Yours sincerely

Dr S Shanmugam
Specialty Doctor in Psychiatry





Intensive Home Treatment Team
Charleston Centre
49 Neilston Road
PAISLEY
PA2 6LY
Telephone: 0141 618 3333



Date: 6th January 2014
Dictated: 3rd January 2014
CHI: 0502823496
Ref: DMcP/SC

PRIVATE & CONFIDENTIAL

Dr Johnstone
Barony Medical Practice
Northcroft Medical Centre
Paisley



Dear Dr Johnstone

RE: Wesley Phillips, Flat 0/2, 51 Thrushcraigs Crescent, Paisley PA2
Date of Birth: 05.02.82 (3496)

As you are aware following my letter dated 30.12.13 Mr Phillips was referred to Intensive Home Treatment Team by staff at Parkhead Hospital for supported early discharge following a 3 day admission on a background of suicidal ideation with multiple social stressors. Staff at Parkhead Hospital did not feel that Mr Phillips required admission at this time due to his decreased levels of risk was referred to ourselves. Unfortunately since our initial referral on 29.12.13 we have only managed to meet with Wesley on one occasion where Dr McAree, Consultant Psychiatrist completed a full psychiatric assessment and it was felt appropriate to look into passing his care back to his Renfrewshire Drug Service worker Margaret Parkinson and Dr McMahon, Consultant Psychiatrist in the near future.

Mr Phillips engagement with I.H.T.T has been very poor. He has been offered in excess of 5 appointments and only attended one. After discussion via telephone today following another non attendance it was agreed between ourselves and Mr Phillips that transfer of his care back to RDS should take place today. We have encouraged Mr Phillips to utilise crisis numbers should he require and he will attend Margaret Parkinson at RDS on Monday 06.01.14. Should you require any further information please do not hesitate to contact the team on the above telephone number.

Yours sincerely

Desmond McPeake
Senior Intensive Home Treatment Practitioner
Intensive Home Treatment Team

Cc Margaret Parkinson / Dr McMahon, RDS



Intensive Home Treatment Team
Charleston Centre
49 Neilston Road
PAISLEY
PA2 6LY
Telephone: 0141 618 3333



Date: 30th December 2013
Dictated: 29th December 2013
CHI: 0502823496
Ref: DMcP/SC

PRIVATE & CONFIDENTIAL

Dr Johnstone
Barony Medical Practice
Northcroft Medical Centre
Paisley
PA3 4AD

F

Dear Dr Johnstone

RE: Wesley Phillips, Flat 0/2, 51 Thrushcraigs Crescent, Paisley PA2
Date of Birth: 05.02.82 (3496)

Please be advised the above named gentleman was referred to the Intensive Home Treatment Team by staff at Parkhead Hospital for facilitation of early discharge. Mr Phillips had been admitted for a 72 hour period following presenting with suicidal ideation on Christmas eve. Whilst an in-patient in the ward his mood has improved and he is no longer voicing suicidal ideation.

Mr Phillips is agreeable to discharge from hospital and I.H.T.T. will engage with him over the coming days with a view to monitoring his continued improvement. We will of course keep you updated on his progress and should you require any further information please do not hesitate to contact the team on the above telephone number.

Yours sincerely

Desmond McPeake
Senior Intensive Home Treatment Practitioner
Intensive Home Treatment Team

Cc Dr McMahon, RDS

20 Back Sneddon Street
PAISLEY PA3 2DJ

Our ref: CD/CL/CHI: 0502823496
Date: 10th December 2013.

Renfrewshire Drug Service
Direct -0141-889-1223
Fax 0141-840-5729

Date Dictated: 3rd December 2013.

PRIVATE & CONFIDENTIAL

Dr. Johnstone,
The Barony Practice,
Northcroft Medical Centre,
Northcroft Street,
Paisley,
PA3.4AD.

Dear Dr. Johnstone,

Wesley Phillips (0502823496).
1/ 4, 17 Abercorn Street, Paisley, PA3.4AA

Psychiatric Diagnosis: F11.2 – Opiate Dependence.

Current Psychotropic Medication: Methadone 50mls daily, supervised, Sertraline 150mgs.

I reviewed Mr. Phillips at Renfrewshire Drug Service on the 3rd December 2013. He tells me today that he has been using heroin and valium again on and off for the past 5 months. He is currently injecting heroin, about ½ grm per day and can be using between 10-15 tablets of street valium per day also. He also notes that he has been gambling and on several occasions had no money for food. However I believe his family have intervened and are being more supportive of Wesley at this time.

Mr. Phillips was interested in having an increase in his Methadone. However I notice that previously ECGs from last year demonstrated a prolonged QT interval. To this end we are arranging for Mr. Phillips to attend for an updated ECG and following this we will revisit his current medication regime.

-2-

Wesley Phillips - CHI: 0502823496

Of note, Mr. Phillips showed me a significant wound from a dog bite from earlier this morning. I have suggested that he attends hospital to have this treated.

Yours sincerely

**Dr. Claire Duncan,
ST3 in Addiction Psychiatry.**

**Dr. Charles McMahon
Consultant Psychiatrist**

20 Back Sneddon Street
PAISLEY PA3 2DJ

Our Ref: CMCM/DC/CHI 0502823496
Date: 22nd May 2013

Renfrewshire Drug Service
Direct: 0141-618-2585
Fax: 0141-618-5267

Date Dictated: 7th May 2013

PRIVATE & CONFIDENTIAL

Dr. Johnstone
The Barony Practice
Northcroft Medical Centre
Northcroft Street
PAISLEY PA3 4AD

Dear Dr. Johnstone

Wesley Phillips (0502823496)
1/4, 17 Abercorn Street, Paisley PA3 4AA (Previous address)

Psychiatric Diagnosis: F11.2 – Opiate Dependence

Current Psychotropic Medication: Methadone 50 mls. daily, Sertraline 150 mgs.

I saw Wesley for further review at the Drug Clinic on 07.05.2013. Wesley looked very well today. He reports very little drug use in recent months. He has established a relationship with a young woman and this seems to have cheered him up considerably. She had a miscarriage a few week's ago. I have suggested to him that perhaps it is a bit early in their relationship to be thinking of starting a family and to pay attention to contraception.

Yours sincerely

Dr. Charles McMahon
Consultant Psychiatrist



Intensive Home Treatment Team
Charleston Centre
49 Neilston Road
PAISLEY
PA2 6LY
Telephone: 0141 842 3434



Date: 5th December 2012
Dictated: 4th December 2012
CHI: 0502823496
Ref: LC/SC

PRIVATE & CONFIDENTIAL

Dr Johnstone
Barony Practice
Northcroft Medical Centre
Paisley
PA3 4AD

Dear Dr Johnstone

RE: Wesley Phillips, 1/4, 17 Abercorn Street, Paisley PA3 4AA
Date of Birth: 05.02.82 (3496)

As you are aware Mr Phillips has been working with Intensive Home Treatment Team since referral on 28.11.12 due to suicidal ideation.

During his time with the team he has been compliant with medication and appears to be doing well with support from his father.

Mr Phillips has been discharged from I.H.T.T. today, 04.12.12 and is now engaging with RCA for help with his gambling addiction.

Dr McMahon, RDS will see Mr Phillips at Out Patients clinic in January 2013 and Mr Phillips has stated he is happy to do so as he feels the service he receives from RDS is appropriate for him. Dr McMahon has increased Mr Phillips Sertraline but as his notes are already with RDS I am unsure of the correct dose.

Should you require any further information please do not hesitate to contact the team on the above telephone number or RDS directly on 0141 889 1223.

Yours sincerely

PP Linda Carroll
Intensive Home Treatment Practitioner
Intensive Home Treatment Team

Cc Dr McMahon, RDS ✓

20 Back Sneddon Street
PAISLEY PA3 2DJ

Our Ref: CMCM/DC/CHI 0502823296
Date Dictated: 13th December 2012

Date: 4th December 2012

Renfrewshire Drug Service
Direct: 0141-889-1223
Fax: 0141-840-5729

PRIVATE & CONFIDENTIAL

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

Dear Dr. Mitchell

Wesley Phillips (0502823296)
Loretto Housing Association, 17 Abercorn Street, Paisley

Psychiatric Diagnosis: F11.2 Opiate Dependence

Current Psychotropic Medication: Methadone 50 mls. daily, Sertraline 150 mgs.

I saw this man for review at the Drug Clinic on 04.12.2012. Margaret Parkinson at Renfrewshire Drug Service and Linda Carroll from IHTT were also present. Wesley has again been presenting to mental health services complaining of vague suicidal ideation and in need of support. I think the current crisis has been precipitated by Wesley gambling to excess. He tells me today he spent over £1,000 and pawned some of his possessions. Nor surprisingly, his father was extremely unhappy about this and threatened to throw his dog out and to cut Wesley off. The worst of the crisis seems to have settled again. Wesley has made up with his father and is full of resolutions regarding his gambling. He says he is in the process of barring himself from local bookies shops and is going to have some way of his father helping to control his money.

As ever, he looked somewhat blunted and flat. He continues to say that he wants to do things and at present is saying that he is going to join in activities at the Charleston Centre and is doing things organised by RCA. The truth of the matter is that Wesley's motivation to change is extremely limited and at my last appointment we went over concerns by Loretto staff that Wesley was not getting up in the day and was not using supports appropriately.

Cont'd/... ..

He presents much as he has over many years. He is rather dependent character who responds poorly to stress. He leads a life without structure or purposeful activity it would appear and really resists any attempts to get him to engage with that.

He says he has not been using drug recently apart from some extra illicit Diazepam, I am not sure if that is the case or not. His ECG shows a continuing prolongation of QTc of around 488 or 490. He is only Diazepam, Methadone and Sertraline. The Methadone is the most likely culprit, although the dose is moderate at 50 mls. I doubt that he would tolerate further reductions or a change to Suboxone at the moment. Wesley is aware of the QTc and is aware of the extreme risk of using other drugs, particularly Amphetamines, Cocaine or alcohol. I think we will simply monitor the situation and repeat the cardiograph again in a few months. If he has not had a recent U&E done I will also check that.

Yours sincerely

Dr. Charles McMahon
Consultant Psychiatrist



Intensive Home Treatment Team
Charleston Centre
49 Neilston Road
PAISLEY
PA2 6LY
Telephone: 0141 842 3434



Date: 29th November 2012
Dictated: 28th November 2012
CHI: 0502823496
Ref: GH/SC

PRIVATE & CONFIDENTIAL

Dr Johnstone
Barony Practice
Northcroft Medical Centre
Paisley
PA3 4AD

file copy.

Dear Dr Johnstone

RE: Wesley Phillips, 1/4, 17 Abercorn Street, Paisley PA3 4AA
Date of Birth: 05.02.82 (3496)

Please be advised that the above named was referred by Out of Hours GP Service for emergency psychiatric assessment to the Intensive Home Treatment Team on the morning of 28.11.12. due to suicidal ideation. Following assessment it appeared that Mr Phillips was suffering from a number of social stressors related to query poly substance misuse and financial issues related to gambling addiction.

It was agreed following discussion with On Call Consultant Psychiatrist that Mr Phillips would benefit from a short period of support and monitoring by the Intensive Home Treatment Team.

We shall keep you updated of our contacts and should you require any further information please do not hesitate to contact the team on the above telephone number.

Yours sincerely

George Hind
Intensive Home Treatment Practitioner
Intensive Home Treatment Team

20 Back Sneddon Street
PAISLEY PA3 2DJ

Our Ref: CMcM/IP/CHI 0502823296
Date: November 19, 2012

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

Date Dictated: November 6, 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

I saw Wesley for further review at the Drug Clinic on November 6, 2012. Things appear to be reasonably settled at the moment. Wesley reports he is abstinent from drugs. He complains of some mild anxiety but appears to be managing. He looks relatively well. He had an ECG a few months back but results appear to have gone astray and I will get that repeated. His current medication is Methadone 50mls daily and Sertraline 10mgs daily.

Yours sincerely

Dr. Charles McMahon
Consultant Psychiatrist



Paisley Community Mental Health Team
The Charleston Centre
49 Neilston Road
PAISLEY
PA2 6LY

Tel: 0141 842 3400
Fax: 0141 842 3415

Date: 30th October 2012
Chi No: 0502823496
Pims No:
Ref: MG/JB



PRIVATE & CONFIDENTIAL

Mr Wesley Phillips
17 Abercorn Street
Paisley
PA3 4AA

Dear Wesley

Thank you for attending the Charleston Centre on the 11th October for an initial assessment. As we discussed you have indicated a need to occupy your time and look for more structured activities. You have indicated an interest in attending college and particularly on plumbing. As you are being fully supported by Renfrewshire Drug Service at the moment it would seem appropriate that you continue to engage with their service and at this moment in time you would not require input from the Paisley Community Mental Health Team.

Thank you again for attending and I would like to take this opportunity to wish you well for the future.

Yours sincerely

Margaret Gill
Community Psychiatric Nurse
Paisley Community Mental Health Team

Copy to; Dr Krishna, Barony Practice, Northcroft Medical Ctr, Northcroft St, Paisley, PA3 4AD

NHS
Greater Glasgow
and Clyde

PIMS No/CHI No:	0502823496	WARD:	PCMHT
NAME:	Wesley Phillips		
ADDRESS:	17 Abbecon St Parsley		
POST CODE:	PA3 4AA		
DOB & GENDER:			

[illegible]



Paisley Community Mental Health Team
The Charleston Centre
49 Neilston Road
PAISLEY
PA2 6LY

Tel: 0141 842 3400
Fax: 0141 842 3415

Date: 10th August 2012
Chi No: 0502823496
Ref: /JB



PRIVATE & CONFIDENTIAL

Wesley Phillips
17 Abercorn Street
Paisley
PA3 4AA

Dear Mr Phillips

Following a referral to the Paisley Community Mental Health Team an appointment has been arranged for you to attend the Charleston Centre for an Initial Assessment on:

THURSDAY 11TH OCTOBER 2012 AT 9.30AM @ THE CHARLESTON CENTRE

The assessment will last approximately one hour.

Should you be unable to attend, please contact the office as soon as possible and another appointment can be arranged.

Yours sincerely

Janette Brown

Janette Brown
Team Secretary
Paisley Community Mental Health Team

Copy to: Dr Johnstone, Northcroft Medical Centre, Northcroft Street, Paisley, PA3 4AD



Paisley Community Mental Health Team
The Charleston Centre
49 Neilston Road
PAISLEY
PA2 6LY



Tel: 0141 842 3400
Fax: 0141 842 3415

Date: 10th August 2012
Chi No: 0502823496
Pims No:
Ref: /JB

PRIVATE & CONFIDENTIAL

Dr Krishna
The Barony Practice
Northcroft Medical Practice
Northcroft Street
Paisley
PA3 4AD

Dear Dr Krishna

Re: Wesley Phillips, 17 Abercorn Street, Paisley, PA3 4AA
Date of Birth: 05.02.82

Thank you for referring the above named gentleman. He attended the Charleston Centre on the 11th October for an initial assessment. Mr Phillips denied any suicidal ideation at present but he did complain of low mood, feeling bored and seemed to lack structure to his day. He described some attempts at self harm, one including cutting himself, trying to drown himself down the toilet bowl and tried to choke himself while he was attending the sheriff court. He has continued to have guilt feelings regarding the circumstances around the death of his mother and feels that he is partly to blame for this. We discussed counselling, and if Mr Phillips feels this would be appropriate, I have supplied him with the information and how to self refer to RAMH Counselling. On further discussion with your colleague, Dr Hallam, and my colleague Margaret Parkinson, Addictions Nurse Practitioner at Renfrewshire Drug Service, Mr Phillips has been offered several supports as I have indicated in the assessment which I have enclosed with this letter. Due to the support he is receiving from Renfrewshire Drug Service and he is under the care of a Consultant Psychiatrist and drug addiction nurse it was agreed following further discussion with my PCMHT colleagues that Wesley would not require any input from the Paisley Community Mental Health Team at this time.

Mr Philips has indicated his intention to attend college as he would like to do some training to become a plumber. I have advised him to contact Reid Kerr regarding this. He also continues to be supported by Loretto Housing in his current tenancy.

Should you wish to discuss this further at any time, please do not hesitate to me on the above telephone number.

Yours sincerely

Margaret Gill
Community Psychiatric Nurse
Paisley Community Mental Health Team

Copy to: Dr McMahon, RDS, Back Sneddon Centre, Back Sneddon St, Paisley, PA3 2PJ
Margaret Parkinson, RDS, Back Sneddon Street, Paisley, PA3 2PJ

Enc:

Hold mean time to
~~disposal of PAC~~

Assess Clinic

Hospital use only	Clinic	Day Date	Time	Hospital No.
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Paw. 10/8/12

Transport required?

REFERRAL LETTER

MEDICAL IN CONFIDENCE

REFERRAL TO

General Psychiatry (Mental Illness)
AC MH Single Pt Entry 16 - 65y

— **Consultant / receiving practitioner**
and/or **specialty clinic**

The Charleston Centre
49 Neilston Road
Paisley
PA2 6LY

— **Hospital and hospital address**

Hospital location code.

C443C

Email address

-

Urgency of referral

ROUTINE

Date of referral

02-Aug-2012

Date sent

03-Aug-2012

PATIENT DETAILS**Surname**

PHILLIPS

Forename(s)

WESLEY

Title

MR

Sex

Male

Date of birth

05-Feb-1982

CHI no.

0502823496

Area of Residence

-

Patient's address

17 ABERCORN STREET ✓
PAISLEY
PA3 4AA

Contact number(s)

Voice: 07523426917

101003996411K

Unique Care Pathway Number: 101003996411K

REGISTERED GP DETAILS**Name**

Dr C Johnstone

GMC code

2596972

GP code

38571

Practice name

The Barony Practice

Practice code

87606

Practice address

NORTHCROFT MEDICAL CENTRE
NORTH CROFT STREET
PAISLEY
RENFREWSHIRE
PA3 4AD

Contact number(s)

Voice: 01418893732

REFERRING GP DETAILS**Name**

Dr G Krishna

GMC code

6094545

GP code

-

Practice name

-

Practice code

87606

Practice address

Contact number(s)

-

RECEIVED 06 AUG 2012

CLINICAL INFORMATION**History of presenting complaint****Presenting complaint**

Description: hearing voices/depression

Comment: Dear Dr,

Many thanks for seeing this 30 year old gentleman who is very well known to you with a past medical history of depression, heroin addiction and multiple drug misuse in the past. He is currently under RDS and is on methadone and sertraline 100 mg for his depression. He was recently seen by IHTT for depression and suicide attempt. Lately he is complaining that he feels low/depressed and claims for the past 2 weeks he has not been sleeping and been awake till 4am and very anxious. He also claims that at times he is hearing voices to kill himself, but has not harmed himself and does not feel he wants to. He is looking for help. He claims he has not been taking drugs for the past few months. Previously in our notes it says he was diagnosed with personality disorders and having very bad manipulative behaviour.

On examination he looks well, good eye contact no suicidal ideations. He asked for a referral to Charleston center either to speak with CPN or a consultant. I would be grateful if you would review him with regards to his ongoing problems. Many thanks.

Yours sincerely
Dr G Krishna
GP Locum

Reason for referral

Care type requested: Out Patient

Expected outcome: Treat

Past medical history**Pre-existing conditions** (High & medium priority - all)

Description	Comment	Date of onset	Date recorded
Methadone dependence	[YEAR OF EVENT 2006]	01-Jan-2006	01-Jan-2006
Emotionally unstable personality	[YEAR OF EVENT 2006]	01-Jan-2006	01-Jan-2006
Drug, medicament or biological substance poisoning NOS	[YEAR OF EVENT 2005]	01-Jan-2005	01-Jan-2005
Self-harm	[YEAR OF EVENT 2005]	01-Jan-2005	01-Jan-2005
Drug, medicament or biological substance poisoning NOS	[YEAR OF EVENT 1999]	01-Jan-1999	01-Jan-1999
Analgesic, antipyretic and antirheumatic drug poisoning	[YEAR OF EVENT 1999]	01-Jan-1999	01-Jan-1999
Gilles de la Tourette's disorder	[YEAR OF EVENT 1997]	01-Jan-1997	01-Jan-1997
Behaviour disorder	[YEAR OF EVENT 1993]	01-Jan-1993	01-Jan-1993
Psychomotor retardation	[YEAR OF EVENT 1986]	01-Jan-1986	01-Jan-1986

Past procedures (High and medium priority - all)

Description	Comment	Date performed	Date recorded
ECG	prolonged QTC	05-Jul-2012	05-Jul-2012
Drug addictn therap-methadone	for opiate addiction new patient	03-Apr-2012	03-Apr-2012

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
PARACETAMOL tabs 500mg	200	tablet	2 TABLET(S) FOUR TIMES A DAY [more]	-	30-May-2012	30-May-2012
ANUSOL HC supp	36	suppository	INSERT ONE AS NEEDED	-	30-May-2012	30-May-2012
ANUSOL HC oint	30	gram	APPLY AS NEEDED	-	30-May-2012	30-May-2012
FYBOGEL HI-FIBRE ORANGE gran	60	sachet(s) orange	1 SACHET ONCE OR TWICE DAILY	-	30-May-2012	30-May-2012

Lifestyle Risks and Alerts / Examinations and Investigations

<u>Description/Question</u>	<u>Result/Comment</u>	<u>Date</u>
Duration of symptoms in weeks:	2	-
Alcohol / drug abuse:	true	-
Referral Reason::	Not Specified	-
VERIFICATION: Social factors section complete:	true	-
Cigarette smoker:	Smoking status on date of event: Smoker, Number of cigarettes smoked per day: 5.	05-Mar-2012
Alcohol consumption:	occ alcohol	05-Mar-2012

Investigations

<u>Description/Question</u>	<u>Result/Comment</u>	<u>Date</u>
Degree of Risk of Suicide:	0 - No suicidal thoughts	-
Past history of suicide attempt:	Unknown	-
Risk from others:	Unknown	-
Risk to others:	Unknown	-
Risk of self neglect:	Unknown	-
Risk to children:	Unknown	-
Risk of wandering and/or falls:	Unknown	-
Challenges to services:	Unknown	-
Cognitive Impairment Score:	Not applicable	-

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 1-6 days):Yes
 Patient has disability or requires wheelchair access:No
 Referred By:Locum
 Electronic Attachment Present:No

Signature of referring doctor (or other professional) **Date**

STRICTLY CONFIDENTIAL

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

East Renfrewshire
Adult Mental Health Services
4C Burnfield Avenue
Giffnock
Glasgow
G46 7TP
Phone : 0141 577 3817
Fax.: 0141 577 3949

Our Ref: CM/JW/1808520
Date Dictated: 18/11/2009
Date Typed: 01/12/2009

Dear Dr Fitzpatrick

WESLEY PHILLIPS, 39 SUNNYSIDE PLACE, BARRHEAD, G78 2RT
DOB: 05/02/1982 CHI - 3946

Date of Admission: 11 November 2009

Date of Discharge: 13 November 2009

Diagnosis: Opiate Dependence Syndrome
Harmful Use of Various Substances

Legal Status: Informal throughout

Medication on Discharge: Mirtazepine 30 mgs at night
Quetiapine 100 mgs twice daily
Methadone 90 mls in the morning

Follow-up: Local Substance Misuse team as previously

Wesley was re-admitted following his discharge the previous week. He had presented to A&E at the RAH after calling an ambulance and saying he was suicidal. The trigger for this was again an argument with his girlfriend. At the time of his admission he reported ongoing suicidal ideation and low mood.

Wesley was settled the night of admission, sleeping well with no extra medication necessary. The following morning he was witnessed to be speaking on the ward phone in a rather animated manner. Following this Wesley was found to be absent from the ward. The duty doctor contacted me about this, however, given that there were no concerns for his immediate safety during the initial assessment and that he does not have a major psychiatric diagnosis I felt that we should keep the bed should he choose to return within the next day or so and then discharge him.

The following day ward staff made contact with his father who confirmed that he was safe and did not intend to return to hospital. This admission again appears to have been triggered by social stresses and again there was no clear evidence of significant psychopathology. Given the above we felt it was not appropriate to keep his bed open any longer and he was discharged back to outpatient care.

Cont/.....

2

WESLEY PHILLIPS, 39 SUNNYSIDE PLACE, BARRHEAD, G78 2RT
DOB: 05/02/1982 CHI - 3946

Cont/.....

Follow-up will be as prior to admission. Should you require any further information please do not hesitate to let me know.

Yours sincerely

Dr Chris Mathias
Staff Grade Psychiatrist

STRICTLY CONFIDENTIAL

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

East Renfrewshire
Adult Mental Health Services
4C Burnfield Avenue
Giffnock
Glasgow
G46 7TP
Phone : 0141 577 3817
Fax.: 0141 577 3949

Our Ref:CM/JW/1808520

Date Dictated

Date Typed:01/12/2009

Dear Dr Fitzpatrick

WESLEY PHILLIPS, 39 SUNNYSIDE PLACE, BARRHEAD, G78 2RT
DOB: 05/02/1982 CHI - 3946

Date of Admission: 23 October 2009

Date of Discharge: 25 October 2009

Diagnosis: Opiate Dependence Syndrome
Harmful Use of Multiple Substances

Legal Status: Informal throughout

Medication on Discharge: Mirtazepine 30 mgs at night
Quetiapine 100 mgs twice daily
Methadone 90 mls in the morning

Follow-up on Discharge: Based on presentation no evidence of ongoing mental health problems. Follow up by Substance Misuse team

Mr Phillips presented following being taken to A&E by his drug support worker. It was felt that he was low in mood and voicing suicidal ideation. Mr Phillips was not assessed by Liaison Psychiatry and instead was transferred first to Dykebar Hospital and then onto Leverndale where I was able to assess him myself. Mr Phillips stated that he had been using heroin since his discharge approximately 18-months ago, and in the run up to his presentation had been using 5 bags daily (between himself and his partner). He had also been using occasional cocaine, crack and benzodiazepines but denied alcohol or cannabis use. He reported low mood for two to three months, mostly due to being unhappy with his social circumstances and reported feeling paranoid. However on closer questioning he had been attacked several times in the area around his home and there was minimal evidence of true paranoia, rather his fears about what may happen to him in Barrhead seemed perfectly justified.

The main precipitant for his presentation was being told that his partner (of approximately two years) had been cheating on him. It seems that she was a considerable stabilising influence in his life and he felt that there was no longer anything.

Cont/.....

He reported persistent low mood but there was no clear anhedonia, his concentration was impaired (but admitted to being distracted by ongoing thoughts of his partner), some fleeting thoughts of self-blame but no clear inappropriate guilt and poor sleep and appetite (present since before the onset of his low mood and most likely linked to ongoing substance abuse).

Mr Phillips reported ongoing auditory hallucinations, heard in the 3rd person in internal space. These mimicked his thoughts but were not clearly echo des pensees and he had full insight into these. They were mood congruent and seemed to be pseudo-hallucinations secondary to anxiety rather than true hallucinations.

I felt following the initial assessment that there was no evidence of significant mental illness, rather that Mr Phillips was experiencing an acute stress reaction due to the potential break-up with his girl-friend. I did not feel that admission was appropriate however Mr Phillips stated that he would not be able to maintain his safety in the community and was unwilling to engage with support services. After some discussion we agreed that a short respite admission may be appropriate to encourage Mr Phillips to engage with community services and I had agreed he could be admitted over the weekend with the provision that he be discharged early next week.

Mr Phillips was settled on the ward with no significant evidence of mental illness. Physical examination on admission was unremarkable but due to his ongoing IV drug abuse we had requested a repeat hepatitis serology, however the results of this were not available on discharge. There was minimal evidence of mental illness on the ward, Mr Phillips was settled, engaged well with staff and fellow patients and there was no objective evidence of psychotic symptoms.

Two days after admission Mr Phillips had contacted his girlfriend and it seemed things had settled between them. At this point he requested to be discharged and as he was clearly not detainable under the Mental Health Act, was discharged on the Sunday. Based on his presentation on the ward it seemed that there is no ongoing significant mental health problem and as such I feel that Mr Phillips would be better supported in the community by Substance Misuse Services rather than the community mental health team. We will keep you informed of any further developments.

Yours sincerely

Dr Chris Mathias
Staff Grade Psychiatrist

cc Substance Misuse Team



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 Athurle Street, Barrhead

PERSONAL DATA SHEET

PIMS No/CHI No:	050282 3496	WARD:	South
NAME:	Wesley Phulp		
ADDRESS:	14F Thrushcraigs Crescent, Paisley		
POST CODE:	PA2 6PP		
DOB & GENDER:	5.02.1982 (m)		

PATIENT CONTACT DETAILS			
TELEPHONE:		MOBILE:	07804144086

PERSONAL DETAILS					
NEED FOR INTERPRETER:	YES	☒ NO	PREFERRED LANGUAGE OR METHOD OF COMMUNICATION	Sadhly	
NATIONALITY:	Sadhly		METHOD OF COMMUNICATION	Verbal	
PREFERRED NAME:			MAIDEN NAME:		
OCCUPATION:	unemployed		NATIONAL INSURANCE No:		
SOURCE OF INCOME:			RELIGION:	Christian	
MARITAL STATUS					
(PLEASE CIRCLE BELOW AS APPROPRIATE, IF OTHER PLEASE STATE)					
☒ SINGLE	MARRIED	SEPARATED	DIVORCED	WIDOWED	OTHER

MEDICAL ALERTS
 E.G. ALLERGIES

GENERAL PRACTITIONER	
GP:	Dr Jalosten
E-MAIL:	
TELEPHONE:	
ADDRESS: Berang Medical Practice POSTCODE: G14 1 889 3132	

PRINCIPAL CARER	
NAME:	RELATIONSHIP:
ADDRESS:	
POSTCODE:	
TELEPHONE:	MOBILE:

NAMED PERSON	
NAME:	RELATIONSHIP:
ADDRESS:	
POSTCODE:	
TELEPHONE:	MOBILE:

DATE SHEET INITIATED:	DATE INFO CHECKED:	NAME:	DESIGNATION	SIGNATURE

PERSONAL DATA SHEET

PIMS No/CHI No:		WARD:	
NAME:	CHI: 0502823496		
ADDRESS:	Phillips Wesley		
	0/2, 51 Thrushcraig Crescent,		
	PAISLEY,		
POST CODE:	Renfrewshire		
	PA2 6PP		
DOB & GENDER:	D/1808520/2 Male		

PATIENT CONTACT DETAILS			
TELEPHONE:		MOBILE:	
			07523426917
			07847292196

PERSONAL DETAILS					
NEED FOR INTERPRETER:	YES	NO	PREFERRED LANGUAGE OR METHOD OF COMMUNICATION		
NATIONALITY:					
PREFERRED NAME:			MAIDEN NAME:		
OCCUPATION:			NATIONAL INSURANCE No:		
SOURCE OF INCOME:			RELIGION:		
MARITAL STATUS					
(PLEASE CIRCLE BELOW AS APPROPRIATE, IF OTHER PLEASE STATE)					
SINGLE	MARRIED	SEPARATED	DIVORCED	WIDOWED	OTHER

MEDICAL ALERTS E.G. ALLERGIES	
---	--

GENERAL PRACTITIONER		
GP:	C. Johnstone	ADDRESS: Barony Practice Northcroft Medical Centre North Croft Street Paisley POSTCODE: PA3 4AD
E-MAIL:		
TELEPHONE:	889 3732	

PRINCIPAL CARER			
NAME:		RELATIONSHIP:	
ADDRESS:			
		POSTCODE:	
TELEPHONE:		MOBILE:	

NAMED PERSON			
NAME:		RELATIONSHIP:	
ADDRESS:			
		POSTCODE:	
TELEPHONE:		MOBILE:	

DATE SHEET INITIATED:	DATE INFO CHECKED:	NAME:	DESIGNATION	SIGNATURE
22.8.12	22.8.12	Anne Corcoran	Clerical Officer	A Corcoran

MENTAL HEALTH & CRIMINAL PROCEDURES ACTS INFORMATION

PIMS No/CHI No:	0502823496 ^{LABEL}	WARD:	Sadly
NAME:	Wasley Phillips		
ADDRESS:	14F Thrusburghs Crescent		
POST CODE:	PA2 6PP		
DOB & GENDER:	5.2.82 (Male)		

DATE & TIME APPLIED	LOCATION/ SERVICE	MH/CPA ACT LEGAL STATUS	DATE & TIME EXPIRES (WHERE APPROPRIATE)	PRINT NAME/SIGN & GIVE DATE AND TIME	
				VERBAL EXPLANATION GIVEN	MENTAL WELFARE COMMISSION INFORMED
		Informal.			

Mental Health {Care & Treatment}{Scotland} Act
2003

**No Advanced Statements or Named Person forms
lodged as of date stated below:**

Date: ..27.8.12.....

Mental Health Partnership
Clinical Risk Screening and Management Tool

Service Users Name: <i>Wesley Phillips</i>	CHI N°/DoB: <i>0502823496</i>	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

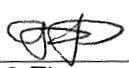
Service user ☒	Carer ☐	Consultant ☐	Other Dr ☐	Occupational Therapy ☐
Named Nurse ☐	Social Work ☐	Psychology ☐	CPN ☐	Voluntary agency worker ☐
Pharmacy ☐	GP ☐	Support worker ☐	Other ☐ specify	

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: <i>C. Phillips</i>	Signature: 
Designation: <i>Staff Nurse</i>	Date & Time: <i>28.9.15 @ 15.45</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					
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 Wesley has been admitted due to suicidal ideation, thoughts of hanging himself, due to voices "god" telling him to. Risk assessed by duty doctor and informal admission on general observations arranged. If concerns are raised or any self harm/ suicidal concerns highlighted then observations will be increased appropriately.	MOT
Violence Wesley has an opiate dependency and has admitted to using 130 bag a day at present. Staff will support Wesley with his dependency and ensure his cravings are matched with substitute. Staff will also provide support and education on the effects opiates have on his mental health.	MOT.
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: C. P. [Signature]	Signature: [Signature]
Designation: Staff Nurse	Date & Time: 28.9.15 @ 16.45

Mental Health Partnership
Clinical Risk Screening and Management Tool

Date	Review of Identified or New Risks	Review of Management Plan	Setting e.g. MDT	Completed by
29.4.15	No new risks identified.	Continue with Management plan	MDT	

Mental Health Partnership
Clinical Risk Screening and Management Tool



Service Users Name: WESLEY RHAPS	CHI N°/DoB: 0502823496	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

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- 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: SEORUK HIND	Signature: <i>[Signature]</i>
Designation: 1st PRATITIONER	Date & Time: 28/9/15 (14.30)

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 (eg. 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.

Risk Management

Risk management planning will flow on from risk formulation. Risk management strategies to consider might include:

- Safe and appropriate levels of nursing observation and engagement
- Use of the Mental Health Act, where appropriate
- Use of low stimulus or secure areas, if appropriate
- Use of suitable medication, when indicated
- Referral to other agencies eg. police, social work
- Liaison and cooperation with relatives or carers
- Referral to Care Programme Approach

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					
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				

Operational Definitions

Not all the variables listed overleaf require further explanation or definition. However, some notes:

■ Suicide

S2	Use of firearms; knives; rope/ligature; jumping off building or bridge; fire; suffocation or gas inhalation.
S3	Includes self harm coming to medical attention and actual suicide attempts.
S5	Record of senior clinician making evidence based diagnosis.
S7	May require third party history to establish. What was purpose, and effect on behaviour of substance use?
S10	Impulsivity is more a behavioural characteristic than a diagnosis. Actions that are poorly conceived, prematurely expressed, unduly risky, or inappropriate to the situation which often result in undesirable outcomes.
S11	How detailed are the plans? Serious intent? Are there precautions against detection, and final goodbyes?
S12	Use of firearms; knives; rope / ligature; jumping off building or bridge; fire; suffocation or gas inhalation.
S13	Could be a manifestation of underlying low mood. Feels trapped or describes external locus of control?
S14	Significant recent (< 1 month) life event, maybe with accompanying behavioural change.
S15	Recent = <1 month, from acute psychiatric inpatient unit, whether planned or not.
S17	Some individuals may respond better to friend or family member, than professional carer.
S18	Is there someone (or a pet) who needs them or loves them?
S19	Catholic and Jewish faiths said to be particularly protective.

■ Violence

V1	Serious or planned acts, that maybe came to others attention. (eg police, carers, medical)
V3	Includes locked residential schools, young offender units, prisons and secure hospital settings/IPCs
V4	Includes homicide, attempted murder, bodily harm, common assault but not always breach of peace
V5	Record of senior clinician making evidence based diagnosis. Psychopathy is classically characterised by impulsivity, callousness, criminal versatility, and a lack of remorse or empathy
V6	May require third party history to establish. What was purpose, and effect on behaviour of substance use?
V8	May require third party history to establish. What was purpose, and effect on behaviour of substance use?
V10	Impulsivity is more a behavioural characteristic than a diagnosis. Actions that are poorly conceived, prematurely expressed, unduly risky, or inappropriate to the situation which often result in undesirable outcomes.
V11	With drink or drugs at the time of assessment
V12	Includes destructive command hallucinations, referential paranoid delusions, and passivity phenomena
V13	Preoccupation with violent thoughts, including recorded and printed material
V14	May indicate the degree of planning
V15	May indicate the degree of planning
V17	Some individuals may respond better to friend or family member, than professional carer.
V18	May be correctional, medical or rehabilitative

■ Other

O1	Not LD per se, but LD leading to potential risk to self
O5	This might be deliberate, or as a result of disability.
O6	Water / heat / light. Is the absence of amenities beyond the individual's control?
O7	Inadvertent or deliberate.
O10	The individual may be inadvertently vulnerable, secondary to mental illness or cognitive impairment.
O11	Speech or cognitive impairment, or cultural / language difficulties
O12	Fluctuating level of consciousness, or delirium, as well as other cognitive impairment
O13	This must be directly witnessed, and be more than inappropriate comment.
O14	It may not be the total debt value, but the impact of the debt that matters
O17	Some individuals may respond better to friend or family member, than professional carer.
O18	Medical, rehabilitative, or social services.

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 THOUGHT AND PLAN TO KILL HIMSELF VIA HANGING, REPORTS VOICE OF MARK (WIKI HIS HEAD (WHICH HE ATTRIBUTES TO GOD) TELLS HIM TO DO THIS. TO	
Violence - BREACH OF PEACE - 42/12 SENTENCE IN 2009 FOR ARMED ROBBERY. - CURRENTLY HAS 2 CHARGES PENDING COURT DATES NOV 2015. - POSSESSION OF DRUGS - SHOPLIFTING.	
Other Risk Factors 1/ MAKE DIAGNOSIS OF EUPD / DISOCIATED PERSONALITY TRAIT 2/ CURRENT IN HEROIN ABUSER 3/ LIVING IN HOMELESS ACCOMMODATION ON HIS OWN. 4/ REPORTS NO CONTACT w FAMILY, NO CLOSE FRIENDS	

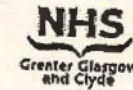
Outcome of screening/management plan discussed with

Service User ☐	Carer ☐	Consultant ☐	Other Dr. ☐
CPN ☐	Ward Nurse ☐	Social Work ☐	Occupational Therapy ☐
Psychology ☐	Pharmacy ☐	Other ☐ specify	

Management Plan completed by

Print Name: <u>STEFAN HEND</u>	Signature: <u>[Signature]</u>
Designation: <u>11th PRISONER</u>	Date & Time: <u>28/9/15 (14.30)</u>

Mental Health Partnership
Clinical Risk Screening and Management Tool



Date	Review of Identified or New Risks	Review of Management Plan	Setting e.g. MDT	Completed by
24.9.15	No concerns. No time out yet!! Detox complete.	No change		

IDENTIFIED NEEDS & RISKS

PIMS No/CHI No:	050282 3496	WARD:	South
NAME:	Wesley Phelps		
ADDRESS:			
POST CODE:			
DOB & GENDER:	0502 82 (m)		

DATE:	NO:	NEED/RISK:	EVALUATION FREQUENCY:	SIGN & PRINT NAME/DESIGNATION:	DATE DISCONTINUED
28.9.15	1	Mental Health, Recovery discharge	weekly	K. Maitl S/N	5.10.15
28.9.15	2	Therapeutic Intervention	weekly	K. Maitl S/N	5.10.15
28.9.15	3	Legal Aspect of CoE	weekly	K. Maitl S/N	5.10.15
28.9.15	4	Physical Aspect of CoE.	weekly	K. Maitl S/N	5.10.15

Client Specific (Inpatient) Moving and Handling Risk Assessment Form

Patient's name:	Wesley Phillips	Named Nurse:	Ben Cullen	If Patient is totally independent, tick here and go to date box	☒	Risk:	Low	Medium	High
BODY BUILD Obese ☐ Tall ☐ Above average ☐ Medium ☐ Average ☐ Short ☐ Below average ☐			Problems with comprehension, behaviour, co-operation (specify): Handling constraints, e.g. disability, weakness, pain, skin lesions, infusions (specify): 						
RISK OF FALLS High ☐ Low ☐									
Transfers (Including To/From: Bed; Wheelchair; Commode; Toilet)									
HOIST/STANDAID (Specify)		ASSISTANCE		SUPERVISION		INDEPENDENT			
Model:		People: 1 ☐ 2 ☐ 3 ☐		Additional Information:					
Sling type:		Walking aid (specify)							
Sling size:									
Toileting									
HOIST/STANDAID		ASSISTANCE		SUPERVISION		INDEPENDENT			
		People: 1 ☐ 2 ☐ 3 ☐		Additional Information:					
Move on / off bed pan									
HOIST		MANEUVRE		ASSISTANCE		SUPERVISION		N / A	
		Roll patient		People 1 ☐		Additional Information:			
		Monkey pole		People 2 ☐					
		Patient bridges		People 3 ☐					
Move up / down bed									
HOIST		HANDLING AIDS		ASSISTANCE		SUPERVISION		INDEPENDENT	
		Sliding sheet		People 1 ☐		Additional Information:			
		Monkey pole		People 2 ☐					
		Rope ladder		People 3 ☐					
Transfer to / from trolley (or bed etc.)									
HOIST		HANDLING AIDS		ASSISTANCE		SUPERVISION		INDEPENDENT	
		Patslide		People 1 ☐		Additional Information:			
		Other		People 2 ☐					
		Fabric sliding aid		People 3 ☐					
Sit up over side of bed									
BED REST		ASSISTANCE		SUPERVISION		INDEPENDENT			
		People: 1 ☐ 2 ☐ 3 ☐		Additional Information (e.g. equipment to be used – swivel cushion):					
Into Bath or Shower									
WHICH BATH		HANDLING AID		ASSISTANCE		SUPERVISION		INDEPENDENT	
Shower		Shower chair		People 1 ☐		Additional Information:			
Variable height bath		Bathing Hoist e.g. Alenti		People 2 ☐					
Bed bath		Sling lifting Hoist		People 3 ☐					
Walking									
NO WALKING		WALKING AID (specify)		ASSISTANCE		SUPERVISION		INDEPENDENT	
				People 1 ☐		Distanced walked / Additional Information:			
				People 2 ☐					
				People 3 ☐					
Other Instructions									
Recording Symbol: ☐ / ☐ X ☐ * ☐									
Date Assessed:		28.9.15							
Assessor's signature:									
Proposed Review date:		28.3.15							

Continuation Sheet

Transfers (Including To/From: Bed; Wheelchair; Commode; Toilet)									
HOIST/STANDAID (Specify)	ASSISTANCE			SUPERVISION	INDEPENDENT				
Model:	People: 1	2	3	Additional Information:					
Sling type:	Walking aid (specify)								
Sling size:									
Toileting									
HOIST/STANDAID	ASSISTANCE			SUPERVISION	INDEPENDENT				
	People: 1	2	3	Additional Information:					
Move on / off bed pan									
HOIST	MANEOUVRE		ASSISTANCE	SUPERVISION	N / A				
	Roll patient		People 1	Additional Information:					
	Monkey pole		People 2						
	Patient bridges		People 3						
Move up / down bed									
HOIST	HANDLING AIDS		ASSISTANCE	SUPERVISION	INDEPENDENT				
	Sliding sheet		People 1	Additional Information:					
	Monkey pole		People 2						
	Rope ladder		People 3						
Transfer to / from trolley (or bed etc.)									
HOIST	HANDLING AIDS		ASSISTANCE	SUPERVISION	INDEPENDENT				
	Patslide		People 1	Additional Information:					
	Other		People 2						
	Fabric sliding aid		People 3						
Sit up over side of bed									
BED REST	ASSISTANCE			SUPERVISION	INDEPENDENT				
	People: 1	2	3	Additional Information (e.g. equipment to be used – swivel cushion):					
Into Bath or Shower									
WHICH BATH	HANDLING AID		ASSISTANCE	SUPERVISION	INDEPENDENT				
Shower	Shower chair		People 1	Additional Information:					
Variable height bath	Bathing Hoist e.g. Alenti		People 2						
Bed bath	Sling lifting Hoist		People 3						
Walking									
NO WALKING	WALKING AID (specify)		ASSISTANCE	SUPERVISION	INDEPENDENT				
			People 1	Distanced walked / Additional Information:					
			People 2						
			People 3						
Other Instructions									
Recording Symbol:		/		X		*			
Date Assessed:									
Assessor's signature:									
Proposed Review date:									

Mental Health Partnership
Clinical Risk Screening and Management Tool

Service Users Name: <i>USLEY PHILIPS</i>	CHI N°/DoB: <i>5/2/82 3496</i>	PIMS N°:
Legal Status: Informal ☒ Detained ☐ Community Order ☐	Ward /Dept / CMHT: <i>1HTT</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 KOLSAH</i>	Signature: 
Designation: <i>SENIOR PRACTITIONER</i>	Date & Time: <i>28/11/12 04:30</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					
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 Hx of D.S.H by cutting arms, tried to drown himself by putting his head in toilet bowl and flushing - tried to choke himself whilst in sheriff court. - tried to head bang and tied shawl around neck whilst AAU today stating "I'll prove to you am suicidal whilst away." - denied any ongoing suicidal ideation / plan or intent and contracting to safety.	
Violence extensive forensic hx in ① charges of carrying offensive weapons served 18/12 of a 3 year prison sentence. Released on a supervised leave order in 2011 to expire next year. ② charged w B.O.P and resisting arrest. ③ Admitted to a robbery.	
Other Risk Factors gambling	

Outcome of screening/management plan discussed with

Service User ☐	Carer ☐	Consultant ☒ <i>Dr MacF</i>	Other Dr. ☐
CPN ☐	Ward Nurse ☐	Social Work ☐	Occupational Therapy ☐
Psychology ☐	Pharmacy ☐	Other ☐ specify	

Management Plan completed by

Print Name: CUATH KOREATH	Signature: 
Designation: SENIOR PRACTITIONER	Date & Time: 20/11/12

PATIENT IDENTIFICATION SHEET

Patient	CHI: 0502823496
Address	Phillips Wesley Inverclyde Centre, 98 Dalrymple Street, GREENOCK, Renfrewshire PA15 1BZ
Date of birth	D/1808520/2 Male
Telephone	

0784 7292196

GP's name	C. Johnstone
Address	Baillie's practice Northcroft Medical Centre Northcroft Street
Telephone No:	889 3732

CHANGE OF ADDRESS
Address
Telephone No:

CHANGE OF GP
GP's Name
Address
Telephone No:

DRUG ALLERGIES	SIGNATURE	REVIEWED (DATE)			
		1	2	3	4

MEDICAL / PSYCHIATRIC CRITICAL INCIDENTS	REVIEWED (DATE)			
	1	2	3	4

2449 03/12

CLINICAL NOTES - NURSING

Phillips Wesley
17 Abercorn Street,
PAISLEY,
Renfrewshire
PA3 4AA

D/1808520/2 Male

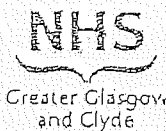
[illegible]



Renfrewshire
Council

EMERGENCY ASSESSMENT REQUEST

IHT TELEPHONE REFERRAL



Date of Referral: 28/11/12		Time of Referral: 00:28	
Name: Wesley Phillips	Sex: M	DOB: 5/2/82	CHI No: 3496
Home Address: 17 Abercorn St flat 1/4		GP: Dr Address: Dr Johnston	
Postcode: G2 3 4AA (Postcodes P1-12 & P14 acceptable. P13 excluded)		Telephone No:	
Telephone No: 848 0854 mobile: 570 2692		Next of Kin/Sig Other:	
Current Location If Different:		Relationship:	
		Address:	
		Telephone No:	

Referrer: DL CJAZ	Agency: 004	Tel No: 6484 041 314 6920
Seen in last 24 hours: YES ☒ NO ☐		
Patient known to psychiatric services: YES ☒ NO ☐ NK ☐		
If yes those involved: Known to RDS		
Legal Status:	CPA (Care Manager):	

Reason for Referral/Current Presentation

Went to bridge in Glasgow to throw himself
off bridge. Went A family and children
noticed past which stopped him & went
back to mother & they contacted NHS
24

Diagnosis: suicidal

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: *don't know*

KNOWN FORENSIC HISTORY: YES ☒ NO ☒

Details: *been in jail*

KNOWN HISTORY OF SELF HARM: YES ☒ NO ☒

(Overdose, cutting, other)

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

Details: *no at home off*

Current medication:

- co-codamol 30/500
- dexam 5mg
- seltaine not sure

Time given for patient to attend:	Procedure if patient not available for assessment: <i>contact police</i>
Location of assessment: <i>AAU</i>	☒ 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:	<i>3:45</i>
Duty Nurse:	YES ☒ NO ☒	Time:	
Duty Dr:	YES ☒ NO ☒	Time:	

Signature: <i>[Signature]</i>	Date: <i>28/11/12</i>	Time: <i>09:31</i>
-------------------------------	-----------------------	--------------------

Call No: 3607785	CHI: 0502823496	Date: 27-11-2012	NHS 24 No: 12401393
Patients Name: Wesley Phillips	D.O.B. Age: 05/02/1982 30 years	Callers Name: Colin Relationship:	
Address Today: 1/4 17 Abercorn Street Paisley Post Code: PA3 4AA Phone Number: 0141 848 0859	Home Address if different: 1/4 17 Abercorn Street Paisley Post Code: PA3 4AA Call Type: PCEC Within 4 Hrs		
Name of GP: Johnston, Christopher(A81) Surgery: A 81 The Barony Practice Practice Number: 0141 889 3732 Speed Dial: CONTACT DETAILS (.) MORNING FAX(0141 889 7502) (.) MAIN TELEPHONE(0141 889 3732)	Time Call Received at NHS 24: 27/11/2012 23:02:20 Time Details Received at GEMS: 27/11/2012 23:27:04 Time Patient Arrived: 27/11/2012 23:44:35 Consultation Start time: 28/11/2012 00:18:40 Consultation End time: 28/11/2012 00:36:12		

Dispatched To: Renfrewshire

Clinical Information

Examination Results:

SAYING HE IS STRUGGLING TO COPE AND IS CONSIDERING JUMPING OFF A BRIDGE IN GLASGOW ((Non-Clinical User) (Glasgow))

HAS BEEN FEELING THIS WAY FOR 12 WEEKS BUT WORSE TODAY ((Non-Clinical User) (Glasgow))

Clinical summary created by: (Nurse Advisor) (Ayrshire (& Arran)) [27/11/2012 23:24:52]

FEELING LOW/SUICIDAL FOR ONGOING AND COLOUR AND BREATHING OK, NIL CHEST PAIN. STATES ONGOING. FEELING LOW. PREVIOUS H/O SUICIDAL THOUGHTS. PREVIOUS ATTEMPTS/ GAMBLING. EVERYTHING GETTING ONTOP OF HIM. FEELS MAY HARM SELF. PCEC WITHIN 4 HOURS RAH

SUICIDAL, TODAY SEE AV

Clinicians Notes

suicidal ideation and threatening to harm himself. States has tried to harm himself in the past several times. No protective factors. Has had recent arguments with his father. Not currently in a relationship. Feeling low. Wishing to throw himself off a bridge or take an overdose. Still feels low. Lives in supported accommodation.

interacting, maintaining eye contact at times, pulse 80 reg, temp 36.5, BP 130/80, chest clear, HS I+II, abdo SNT, BS N,

ongoing suicidal ideation

Refer Dykebar hospital, patient doesn't have own transport. 1 hour ambulance ordered ref number 4388256. r/v prn

Prescription Items:

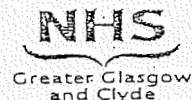
Clinical Code/s: 1B19. Suicidal

Informational Outcome: Hospital Referral

Referral: Consulting Clinician: Ejaz, Mohsin(CC)



ACUTE ADMISSION UNIT DYKEBAR HOSPITAL



COMMUNICATION WITH GP/REFERRER FOLLOWING EMERGENCY ASSESSMENT

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

PATIENT INITIALS	PWP	POST CODE	PA3	4AA
CHI	0502	82	34	96
GP NAME	Dr. Christopher Johnston			
GP SURGERY	The Barony Practice			
PATIENT KNOWN TO PSYCHIATRIC SERVICES	YES ☒ NO ☐			
IF YES: KNOWN TO:-	RDS			

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 ideation

PRESENTING PROBLEM

**30 M saying he is struggling to cope and wanting to jump off a bridge in Glasgow after an argument with his father threatening to throw away his dog
but has been feeling lack of motivation for 16 weeks since Fluoxetine and Quetiapine was stopped and commenced on Sertrodine.**

MENTAL STATE

**presented casually, good eye contact
speech normal tone flat rhythm
mood and affect - euthymic reactive
no perceptible delusions/hallucinations
no evidence of psychotic symptoms
Chrysin - not formally assessed but oriented to time place
good insight**

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

**Discussed with SpR McKie
IHT input
Dr. McMahon to be informed**

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	CMH	ASSESSORS SIGNATURE	R
PRINT NAME	Maury Salve	PRINT NAME	SVAN KORSAH
DESIGNATION	GP 12	DESIGNATION	SENIOR PRACTITIONER

DATE	28	11	12	TIME COMPLETED	03	30
FAXED TO:						
FAXED BY						
DATE				TIME		

ACUTE ADMISSION UNIT DYKEBAR HOSPITAL



Patient Surname	Phillips		
Forename	Wesley		
Address	1/4 17 Abercorn Street Paisley PA3 4AA		
Town			
Post Code	PA	3	4AA

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

ADULT EMERGENCY ASSESSMENT

Date Assessed: 2 8 1 1 1 2 Time of Assessment: (24 Hour Clock) 0 2 3 0

Personal Details			
Surname	Phillips	CHI Number	0502823496
Forename & Initial	Wesley	Marital Status	Single
Previous Name(s)		Legal Status	Review Date: / /
Date of Birth	05.02.82	Advanced Statement	Yes ☐ No ☐
Address	Flat 1/4, 17 Abercorn Street	Named Person	
	Paisley 51THURKRAIS	CPA	Yes ☐ No ☒
Post Code	PA3 4AA 9/2 CRES	Religion	Christian
Telephone No.	0141 848 0859	Present Occupation	
Mobile No.	07591 169 207	Interpreter Required	Yes ☐ No ☐
	07804144086	Adult at Risk AP1 Form	Yes ☐ No ☐
Risk to Staff:			
Next of Kin		Resides with	Lives alone
Relationship		Relationship	
Address		Tel No.	
		Consent to Involve	Yes ☐ No ☐
Post Code		Dependants: Names	DOB
Telephone No.			
Mobile No.			
Consent to Involve	Yes ☐ No ☐		
Height	6ft	Hair Colour	Light brown
Weight	18 stone	Eye Colour	Blue
Build	Heavy	Distinguishing Marks	Tattoo on right forearm, DSH scar
Sex	Male ☐ Female ☐	General Appearance	
Allergies		Driving	Yes ☐ No ☐
REFERRED BY (Name) :- Dr Ejaz			
& AGENCY/DESIGNATION :- Out of Hours GP			
CONTACT No.-			
ASSESSMENT LOCATION: AAU, Dykebar			
ASSESSMENT OUTCOME			
ADMISSION	YES ☐ NO ☐	CMHT	YES ☐ NO ☐
HOSPITAL	WARD	OUT PATIENT REQUEST	YES ☐ NO ☐
		IHTT	YES ☐ NO ☐
ANY OTHER INFORMATION:			
ASSESSSED BY -			
NAME	Evah Korsah	NAME	Dr Mary Salvia

**ADULT EMERGENCY ASSESSMENT
DYKEBAR HOSPITAL**

Existing Services involved in care (next appointment due)	
GP: Dr Johnston, Barony MP, Paisley	Psychiatric Consultant:
Telephone No: 0141 889 3732	Telephone No:
Social Worker:	CPN:
Telephone No:	Telephone No:
Other: Margaret Parkinson, RDS Worker	Other:
Telephone No: 0141 889 1223	Telephone No:

PRESENTING PROBLEMS AND ASSESSMENT OF RISK

(as expressed by client/carer and assessor):

Referred by Out of Hours GP due to suicidal ideation and plan to throw himself off the bridge. Patient described having seen his CPN Margaret Parkinson – told her he was not coping and she referred him to Gambling Anonymous. Had an argument with his dad later this evening about his gambling and not wishing to look after his dog which made him upset and later had suicidal thoughts.

Reports to have constant suicidal ideation for the last 3 months but unclear of what is preventing him from completing it. He reports he walked to Govan to jump off the bridge. He went to the bridge but saw a family walking by hence he was stopped from doing it. He returned to father's house for some clothes and food then chose to go to own flat.

He reports to have been phoned by a friend who advised him to attend Dykebar for admission (his friend [REDACTED])

Patient became angry and walked out from assessment when he felt he would not be admitted to hospital. Staff followed him outside at which point he was observed to be head-banging against the wall and when staff attempted to stop him he tied his jacket around his neck stating and threatening to kill himself unless he was admitted. He became more hostile and aggressive to staff, threatening "legal action". Police were called and attended the scene. Patient agreed for assessment to continue. Much calmer and settled for the duration of assessment.

At this point patient denying ongoing suicidal thoughts plans or intent and requesting help.

Patient contracted to safety and crisis plan agreed with patient. Patient was on Fluoxetine and Quetiapine but these medications were stopped by RDS 16 weeks ago. Awaiting ECG. He is currently Prescribed and taking Sertraline 100mg daily.

Appetite – stable.

Sleep – no problems / changes. Sleeping increased but this has been chronic in nature.

Concentration – okay.

Motivation – lacking motivation and daily structure.

Mood – low.

Enjoyment – spending time with his dog, gambling and friendships.

Energy – no recent change.

Denies any psychotic symptoms.

**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):

Seen by Psychologist since aged 7.
Diagnosed with Tourettes disorder and with emotionally unstable personality.
Currently attends RDS.

CURRENT MEDICATION

NAME	DOSE	FREQ	CURRENT	OTHER INFO
Sertraline	100mg	OD	Yes	
Methadone	50ml	OD	Yes	Often misses picking up methadone
				Due to oversleeping and "lack of
				Motivation".

ATTITUDE TOWARDS MEDICATION (including history of concordance):

Not sure, does not feel it is working.

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

Medications stopped by RDS due to abnormalities in ECG results.

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

Mother	Died in 2007.
Father	Parents separated in 2002.
Siblings	Has 2 older brothers. [REDACTED]
Children	None.
Family Psychiatric History	[REDACTED]

**ADULT EMERGENCY ASSESSMENT
DYKEBAR HOSPITAL**

PERSONAL HISTORY	
Birth / Childhood	Born in Germany, returned to Glasgow aged 2. Happy childhood.
School / Education	Suspended from school due to short temper. Expelled aged 14.
Primary/ Secondary Qualifications	
Occupations	Spent in care home or parents – not coping.
Relationships (including psycho sexual)	Single.
Premorbid Personality	Reports he is a good person.
SOCIAL CIRCUMSTANCES	
ACCOMMODATION and FINANCES:	
Lives in Homeless supported accommodation in Loretto (Abercorn Street). Receives DLA and ESA.	
OCCUPATIONAL and DAYTIME ACTIVITIES:	
Gambling most of his money. Watching TV at night, sleeps during the day.	
PERSONAL CARE and DAILY LIVING SKILLS:	
No issues.	
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):	
Strained relationship with father recently as father threatened to give up his dog-sitting duties.	

ADULT EMERGENCY ASSESSMENT
DYKEBAR HOSPITAL

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

Long history of Polysubstance misuse.

FORENSIC HISTORY (past and present)

Charged with carrying an offensive weapon.
Served 18 months over 3 year prison sentence.
Released on supervised order in 2011 due to expire next year.
Charged with breach of the peace and resisting arrest.
Admitted to committing 2x robberies.

MENTAL STATE EXAMINATION

APPEARANCE & BEHAVIOUR:

Shabbily dressed, heavy built. Hostile and argumentative initially but settled and calm at the end.
Difficult rapport, maintaining eye contact.

MOOD & AFFECT (Objective & Subjective):

Subjectively – rates mood as 5/10, low.
Objectively – reactive.

SPEECH & THOUGHT FORM:

Spontaneous, at times angry and loud but normal rate and rhythm.

THOUGHT / CONTENT

No formal thought disorder.
Seeking respite in hospital and angry that some patients got admitted but he wasn't.

PERCEPTUAL ABNORMALITIES:

Denied hallucinations auditory, visual or olfactory.
No evidence of responding to unseen stimuli.

COGNITION:

Grossly intact.

INSIGHT:

Good.

ADULT EMERGENCY ASSESSMENT
DYKEBAR HOSPITAL

INFORMATION GAINED FROM OTHER SOURCES (collaborative information):

K Drive, GP letter.

CLIENTS EXPECTATION OF REFERRAL/SERVICE (recovery focused):

Admission to hospital.

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

None present.

SUMMARY (including impression, identified strengths and risks):

30 year old gentleman well known to RDS presented with suicidal ideation in context of social stressors, inconsistent reports of current drug misuse. No real evidence of pervasive mood disorder. Nil psychotic symptoms. Initially reluctant to guarantee safety but agreed to same by the end of assessment.

RELEVANT STRESSORS:

Threat by father to throw out his dog.
Gambling his money.

PROTECTIVE FACTORS:

His dog.

PLAN:

Discussed with SpR Dr McKie, liaise with RDS as regards to management plan for patient.

1. IHTT input and visits to be carried out in Abercorn Street.
2. IHTT need to liaise with Abercorn Street staff to arrange an appropriate room for further assessment/visit/contact due to patient's forensic history.
3. IHTT to call patient afterwards with time of visit.
4. Medical review.
5. ECG, bloods to be arranged.
6. Please liaise with RDS re long term management plan.

**ADULT EMERGENCY ASSESSMENT
DYKEBAR HOSPITAL**

DISCUSSED WITH: Dr McKie, SpR	
Assessors signatures:	
PRINT& DESIGNATION	
1: Dr Mary Salvia	Duty Doctor
2: Evah Korsah	IHTT Senior Practitioner

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 { }

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
28/11 9 ⁵⁰	T/C PLACED TO HOMELESS UNIT. WESLEY STILL IN BED, STAFF FINDING IT DIFFICULT TO ROUSE HIM AS HE DIDN'T GET BACK UNTIL 4 ³⁰ AM (SNORING LOUDLY) STAFF WILL ATTEMPT TO WAKEN HIM IN AN HOUR AND ADVISE TO CONTACT STAFF TO ARRANGE APPT.	
10 ⁴⁰	T/C TO M. PARKINSON (RDS) WORKER FOR WESLEY. REPORTED WESLEY HAD TURNED UP YESTERDAY (RDS) AND CLAIMED TO HAVE GAMBLLED £400 OF BENEFITS MONEY, SUBSEQUENTLY FALLING OUT WITH STEP-DAD. THIS SEEMS TO BE A PATTERN FOR WESLEY. NOT DISTRESSED/SUICIDAL.	SEN PRAC T HICKEY AKH
PLAN	MARGARET TOOK HIM TO PCA WHERE HE WAS SEEN BY [REDACTED] WITH REGARDS HIS GAMBLING.	
	- GIVEN A FURTHER APPT BY MARGARET FOR TODAY 28TH AT 11 ³⁰ RDS	
	- OFFERED MENS GROUP BUT DECLINED SAME YESTERDAY AND PREVIOUSLY.	
	- DR MCMAHON APPT TUES 4TH 3 ²⁰ AS LAST ECG SOME ABNORMALITIES NOTED.	

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
Comb	FURTHER TO ABOVE INPUT ALSO IN SUPPORTED ACCOMMODATION BUT CHOOSES NOT TO SPEAK WITH STAFF WHO MAKE THEMSELVES AVAILABLE TO HIM. - MARGARET REPORTS WESLEY SLEEPS ALL DAY. - SHE HAS CONTINUALLY PROVIDED STRUCTURE / ROUTINE WITH LORETO STAFF - ALSO ATTEMPTED PRACTICAL PROBLEM SOLVING, HOWEVER WESLEY UNWILLING TO ENGAGE AND CONTINUED POOR ENGAGEMENT NOTED AT APPOINTMENTS.	
	MARGARET SURPRISED AT REFERRAL TO IHTT, SUFFICIENT PLAN PUT IN PLACE YESTERDAY. WESLEY CURRENTLY ON METHADONE 50ML / SERTRALINE 100MS.	
	ADVISED MARGARET OF APPT AT C/C TODAY 3PM, SHE WILL RECONTACT REITERATE TO WESLEY.	AKELLY
11 ⁰⁰	1/C PLACED TO LORETO STAFF WESLEY STILL IN BED, ADVISED OF 3PM APPT TODAY AT C/C WITH IHTT.	AKELLY

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
28/11/12	Patient phoned @ 3PM to state he was running late. Arrived 3-45	
	Reports poor sleep last night.	
	Though contradicts himself by stating he spends time sleeping	
	Spoke about his addiction to gambling - lasted over a year. Previously states he was addicted to heroin.	
	Spoke of spending £1000 and selling his PS Vita. Pawned for £100.	
	Gets some buzz from gambling but this is short lived.	
	Retains insight that gambling ultimately results in loss.	
	Continues on Sertraline 100mgs and Methadone 50ml	
	Hopes to get dose of methadone reduced. Was increased 1 month ago from 30ml.	
	Hopes to reduce methadone gradually.	
	Spoke of friend [REDACTED] who is in Dykebar - who was friendly with him while in hospital, saying he was very helpful towards him.	
	Gambles whenever he gets his money.	
	Gets D.A. since age of 14yrs - had ADHD and Tourette's Syndrome.	
	Sometimes still gets TICS.	

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
28/11/12	Spoke of death of mother 5 years ago - feels guilty that his behaviour caused/quickened her death - congestive heart failure.	
	Wants to turn life around. - understands his father is suffering stress.	
	Admits his behaviour can be impulsive, then regrets actions. Suicidal ideation persists though no intent at this.	
	Claims his dog has abandonment anxiety and stressor of Dad getting his dog impacts on his mood. Worries he may finalise rejection of dog.	
	Spoke of meeting with R.C.A. - yesterday found it helpful. Admits he has addictive personality.	
	Spoke of interests - snooker, pool, snooker. Interested in getting involved in some activity.	
	Will pop in tomorrow to see M. Parkinson as he did not see her today, overslept.	
	Safe Plan daily dispenses of Methadone. Serrtraline. Crisis numbers in possession Seeing R.C.A. for budgeting.	
	Reports engagement with services have been poor. Lacks motivation.	
	Admits to using chazepam occasionally from friends.	

[illegible]

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
29/11/12	Wesley attended appointment as scheduled.	
11:30am	Mental health state has improved, as he was noted to be reactive, and had good eye contact. His affect was flat although he expressed feeling better. Cognition was noted to be good as expressed in conversations. Wesley stated persistence in substance misuse including alcohol, heroin and diazepam and he is aware of the consequences as he is involved with RDS.	
	- Suicidal ideation was reported, although no intent or plan is in place, and Wesley is keen to seek help regarding this.	
	- Wesley also stated that today he was planning to meet his ex-girlfriend after the appointment which shows improvements in the way he is feeling.	
	- No child protection issues raised.	
	- Not agitated, argumentative or hostile to staff.	
	Plan	
	1) Medical review with Dr McAree at 10:00 on 30/11/12 at CLC.	
	2) Bloods and ECG to be organised at tomorrow's appointment.	
	3) Wesley will get in touch with IHTT if in crisis/if situation gets worse in-between	Jessa Mason Therapist (Student)
		George Hendry IHTT PRISONER
29/11/12	Team meeting	Jessa Mason Therapist (Student)
16:05	Mental state improved as detailed above, Plan	
	Medical review with Dr McAree on 30/11/12 at 10am CLC	

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
30/11/12.	Seen & B. Gibson at c/centre. HA noted. med's noted - don'ty script vol 2 of red notes. "gamble all my money away" - last night. concerned that dad will give dog away. "everything I've ever had in my life I've lost". Can brought to G men last week → thinking about going again. "I need structure during my day". "I gamble or sleep my life away" → long term. Upset because of this - fruit & death of mother - feels father blames him. care - - subj 1 poor. app - each of money gets in way / eats if out dad's. sleep - lies on couch ^{away} for most of day. Can be tempted in months. Engage pool - hoping to manage plan. "worthless" - feels this to family → long term thought. Mum's felt "no good to my family, would be better off dead" → long standing thought. anyway thoughts of suicide - vague plan / no intent. Thoughts appear longstanding. Would call for help, contacting ^{family} love. Her future focus. Dog protective - worried he may lose. Seem to want to engage. Hear	

Crisis no's

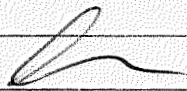
3.2025 / 11/2 Sent

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
	variation - "now & again": slightly erratic. + intervention - last few days ago - "that day I was going to jump myself off the bridge".	
	Series alcohol.	
	"psychiatric"	
	musty large o→. clonidine x1. Engagement ok. Timid. ? incoherence. ? intellectual ability Spoke slowly, coherent. Some reactivity subj: low. obj: upset, not presenting as having a major depression. "psychiatric".	
	D/W	
	- need for collaborative working → responsibilities of each party in Rx. - Structure → talked q. a lot about change + 1st steps. - Practical issues → he just a money man. Asked to inquire	

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
	first parcel. Can get support from team if wishes. There have suggested on point of structure today. • Gambling - encourage G.A. • Dog - spoke about reality that he may lose his dog. Seemed accepting of this, if sad. (not hopeless, did not seem to T suicidal). Have to let team know what happens & this. Seem to be some motivation to him to change → offered by himself. Still some hope he may be able to broker a deal & his dad. • T/C Sat. Visit Sun. go to T/C & Dr MacMahon on Tues. • try to move away from medication being seen as sole solution. Imp: long term cliff. long term risk - ongoing - no sense of significant elevation at present. (need to be aware of potential for T if loses dog). Substance misuse. Gambling issues. Not significantly depressed.	

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
	Myt Parkin called after initial further update. we are in agreement on to need Rx plan + pers. Appt & 2nd MacMahon → 3.20pm on Tuesday.	
30/11/12 16:00	Team meeting.	
	- See mental health summary for today's update	
	Plan for E/C tomorrow	
1.12.12	T/C TO WESLEY. NO REPLY TO HIS MOTHER I TELEPHONED CEMETRY HAVING WIFE REPORTED HE WAS SPENDING W/THINK WITH DAD. I TELEPHONED HIS DAD'S AND SPOKE TO WESLEY WHO SAID HE WAS OK NO PROBLEM OR CURRENT TO GET HOLDING. H/R	DB MURPHY SNR NURSING (MKT)
	PCATV Y HV 2-4 AT WESLEY'S ADDRESS. TOMORROW 2.12.12	G. S. Gifford G. S. Gifford 1/HV ANTI-DRUG
2/12 16:	Telephone call from Wesley. canceling apt for today no concerns. raised at time of call next apt. H/V (Lorrob) 3/12 2-4	E. White E. White support W/L
3/12/12 16:00	H/V at Wesley's address, Wesley wasn't in, tried his mobile and buzzer without success. The support informed us that Wesley was aware of the appointment and had informed her that his mood is low today. Left a note at Wesley's flat	CONT...

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
4/14/12	gambler ~ £1500, passed things Dad threat to kick out by still in Loretto. NA co-owning property in Loretto QTC 490ms Nov 1488ms Ayr Asphyxia buy violin for tie to tie No use in house No drink. Sp will go to school in Chelish Centre Rept sports grounds Laws a little flat no present degree for, no grade since it very chronic pain dependent purely drink needs party 1. stars NA eye change r school 150g	
15/1/13	man arriving. Managed drinks, gambly again Sp he will go to live in RCA hasn't been for bloods - missed some ppb he for blood tests	
16/4/13	DNA for	

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
7/7/13	gifford had a message E her 3/12, will b have a habit cheered up, s thg sh - dead - looks well	
26/8/13	DNA extra contact i M Pdin no real concern -> for C	
1/10/13	now on IV heroin next weeks taky valin yo! poor sleep + anxiety wants about four 2 bond care glithy for gifford want her for an ECG ? try safety feeding	
3-12-13	ADS-OPC Methadone 50ml, daily supervised. Been using again heroin a valin again for past 9/12. Heroin - 1/2 gram per day (120) - injecting. Using street valin 10-15 / day. No alcohol. Been gambling. Keen for increase in Methadone but note less severe ECGs with QT - nil recent (last 2012). - will require updated ECG prior to meds. been bitten by dog today - advised attend GP ^{clayes} for tetanus.	

0141 618 5381 fax



FACILITATION OF EARLY DISCHARGE
ASSESSMENT REQUEST



IHTT TELEPHONE REFERRAL

Date of Referral: 27.12.13		Time of Referral: 11.15	
Name: Wesley Phillips	Sex: M	DOB: 05.02.82	CHI No: 3496
Home Address: 1/2, 51 Thushcraigs Cres Paisley (41) 24 Cleave St Seedhill (Glasgow)		GP: Dr Johnston Address: Barony MP Telephone No: 889 3732	
Postcode: PA2 6PP		Advise patient to be seen on ward prior to discharge, accept in exceptional circumstances eg: out of sector.	
Telephone No: 07804144086		Tick here	
Mobile: 07523 426 917 (?)			

Referrer: Dr Mason	Agency: Parkhead Hosp	Tel No: 211 8309
Admission Date: 24.12.13		
REFERRALS COMPLETED ON WARD (by whom)		
CMHT INVOLVED YES NO (IF YES WHOM) ADDICTIONS - DR M STANON		
Legal Status: 102	CPA (Care Manager): NO	

DIAGNOSIS: PERSONALITY DISORDER

REASON FOR ADMISSION:

Admitted - Suicidal thoughts. 24/12/13 - from A+E.
Jumped in front of a taxi.

PROGRESS ON WARD: (Including risk to self or others) -

Feeling better. Over. Not sharing anything
other than social + drug problems.

Sleeping + Eating well. Interacting well (crisis admission)

EXPECTED IHTT INTERVENTION:

Ongoing assessment of mental state.

Being very mismanaged this year.

Gambling - Acute precipitant, Over family money
but spent it all.

Any children at home: YES ☐ NO ☒

Names:

Gender

D.O.B.

Current location / carer:

History of alcohol abuse: YES ☐ NO ☒ Past ☒ Present ☐

History of drug abuse: YES ☒ NO ☐ Past ☒ Present ☐

KNOWN HISTORY OF AGGRESSION/VIOLENCE :

YES ☒ NO ☐ Past ☐ Present ☐

Details:

Potentially dangerous to others ☐

Bopence - See below

KNOWN FORENSIC HISTORY :

3 1/2 years. YES ☒ NO ☐ Past ☐ Present ☐

Details:

Potentially dangerous to others

Dr times he will be OK for 3 1/2 years. PRISON - ROBBERY WITH A WEAPON 2007. visits

KNOWN HISTORY OF SELF HARM :

YES ☒ NO ☐

(Overdose / cutting / other)

Parasocial Attempts + Self harm - Parasocial (Scars on face arms)

Current medication: (including proposed changes)

Melalone 5mg - daily
Sertaline 150mg -

Q.T. Aetipirein
put ? 5mg

Time and ward of assessment

One 2-3pm -

Allocated assessors:

INFORMED:

Signature:



Date:

27/12/13

Time:

11:40

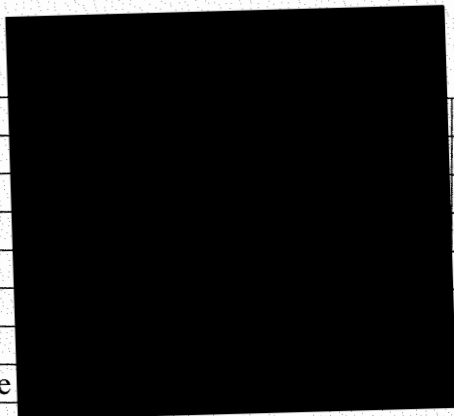
ADULT EMERGENCY ASSESSMENT

Date Assessed: 2 8 1 2 1 3 Time of Assessment: (24 Hour Clock) 1 4 3 0

Personal Details

Surname	Phillips	CHI Number	0502823496
Forename & Initial	Wesley	Marital Status	Single
Previous Name(s)		Legal Status	Review Date: / /
Date of Birth	05.02.82	Advanced Statement	Yes ☐ No ☐
Address	0/2, 51 Thrushcraigs Cr	Named Person	
	Paisley	CPA	Yes ☐ No ☒
Post Code	PA2	Religion	Christian
Telephone No.		Present Occupation	
Mobile No.	07804144086	Interpreter Required	Yes ☐ No ☐
		Adult at Risk AP1 Form	Yes ☐ No ☐

Risk to Staff:

Next of Kin		Resides with	Lives alone
Relationship		Relationship	
Address		Tel No.	
		Consent to Involve	Yes ☐ No ☐
Post Code		Dependants: Names	
Telephone No.		DOB	
Mobile No.			
Consent to Involve			

Height	6ft	Hair Colour	Light brown
Weight	18 stone 17 Stone	Eye Colour	Blue
Build	Heavy	Distinguishing Marks	Tattoo on right forearm, DSH scar
Sex	Male Female	General Appearance	
Allergies	None	Driving	Yes ☐ No ☒

REFERRED BY (Name) :- Dr Mason

& AGENCY/DESIGNATION :- Parkhead Hospital

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:

ASSESSED BY -

NAME	Desmond McPeake, Snr IHTT Practitioner	NAME	
------	--	------	--

**ADULT EMERGENCY ASSESSMENT
DYKEBAR HOSPITAL**

Existing Services involved in care (next appointment due)	
GP: Dr Johnston, Barony MP, Paisley	Psychiatric Consultant: Dr McMahon
	Renfrewshire Drug Service
Telephone No: 0141 889 3732	Telephone No:
Social Worker:	CPN:
Telephone No:	Telephone No:
Other: Margaret Parkinson, RDS Worker	Other:
Telephone No: 0141 889 1223	Telephone No:

PRESENTING PROBLEMS AND ASSESSMENT OF RISK

(as expressed by client/carer and assessor):

Referred for early discharge from Parkhead Hospital following presenting with suicidal ideation.
Admission was for 3 days.

History of opiate dependency and personality disorder. Since admission has been settled, exhibiting drug / social problems.

Known to Dr McMahon at Renfrewshire Drug Service.

Previous episodes of DSH.

History of Tourette's syndrome.

Long history of Police involvement – incarcerated for carrying weapons, assault and robbery.

Issues with gambling, owes family money.

Sleep - 8-10 hrs broken
Appetite -

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

Seen by Psychologist since aged 7.

Diagnosed with Tourettes disorder and with emotionally unstable personality.

Currently attends RDS.

CURRENT MEDICATION

NAME	DOSE	FREQ	CURRENT	OTHER INFO
Sertraline	150mg	Daily		
Methadone	50mls	Daily		

ADULT EMERGENCY ASSESSMENT
DYKEBAR HOSPITAL

ATTITUDE TOWARDS MEDICATION (including history of concordance):	
Past non concordance with medication. Collects daily from local pharmacy.	
CURRENT HEALTH ISSUES/MEDICAL HISTORY (including any disabilities, smoking status, investigations)	
Irregular ECG in past. Ex IV drug user.	
FAMILY HISTORY (including family, education, occupation, parental/siblings relationships, childhood trauma):	
Mother	Died in 2007. - [REDACTED]
Father	Parents separated in 2002. - [REDACTED] [REDACTED]
Siblings	Has 2 older brothers. [REDACTED] [REDACTED]
Children	None.
Family Psychiatric History	[REDACTED]

PERSONAL HISTORY	
Birth / Childhood	Born in Germany, returned to Glasgow aged 2. Happy childhood.
School / Education	Suspended from school due to short temper. Expelled aged 14.
Primary/ Secondary Qualifications	
Occupations	Spent in care home or parents – not coping.
Relationships (including psycho sexual)	Single.

ADULT EMERGENCY ASSESSMENT
DYKEBAR HOSPITAL

Premorbid Personality	Reports he is a good person.
SOCIAL CIRCUMSTANCES	
ACCOMMODATION and FINANCES:	
Lives in Homeless supported accommodation in Thrushcraigs. Receives DLA and ESA.	
OCCUPATIONAL and DAYTIME ACTIVITIES:	
Gambling most of his money. Watching TV at night, sleeps during the day.	
PERSONAL CARE and DAILY LIVING SKILLS:	
No issues.	
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):	
Strained relationship with father recently as father threatened to give up his dog-sitting duties.	
ALCOHOL and ILLICIT DRUG USE (current and past, previous detox programmes/seizures, Methadone, IV use, cigarette smoking, misuse of prescribed medications)	
Long history of Polysubstance misuse.	
FORENSIC HISTORY (past and present)	
Charged with carrying an offensive weapon. Served 18 months of a 3 year prison sentence. Released on supervised order in 2011 due to expire next year. Charged with breach of the peace and resisting arrest. Admitted to committing 2x robberies.	

ADULT EMERGENCY ASSESSMENT
DYKEBAR HOSPITAL

MENTAL STATE EXAMINATION

APPEARANCE & BEHAVIOUR:

Shabbily dressed, heavy built. Hostile and argumentative initially but settled and calm at the end.
Difficult rapport, maintaining eye contact.

MOOD & AFFECT (Objective & Subjective):

3/10
Subjectively - feeling low - wants help with drugs & gambling addiction
Objectively - Recent loss of friend, girlfriend miscarried

SPEECH & THOUGHT FORM:

normal rate tone & rhythm

THOUGHT / CONTENT

PERCEPTUAL ABNORMALITIES:

HEARD VOICES - PRIOR TO JUMPING IN FRONT OF TRAIN - HEARD VOICES FOR 15 YEARS -

COGNITION:

INSIGHT:

Good insight

INFORMATION GAINED FROM OTHER SOURCES (collaborative information):

CLIENTS EXPECTATION OF REFERRAL/SERVICE (recovery focused):

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

**ADULT EMERGENCY ASSESSMENT
DYKEBAR HOSPITAL**

SUMMARY (including impression, identified strengths and risks):

31 year old man with drug and gambling addiction - recent discharge from Parkhead hospital. History of personality disorder. Double payment from NLA - Monday 23/12/12 - ~~Food~~ black out on Tuesday 24/12/12 - admitted to Parkhead suicidal ideation - wants to re-engage with RDS and gets medication sorted.

RELEVANT STRESSORS:

Recent psychiatric discharge.
Gambling debts.
Drug Addiction
Poor Family Relationship - Mums anniversary of death

PROTECTIVE FACTORS:

~~His dog~~ Friends, Being A Christian.

PLAN:

- 1/ IHTT input - 1/24
- 2/ Link in with RDS - Mgt Parkinson
- 3/ Crisis numbers given.

DISCUSSED WITH:

Assessors signatures:

PRINT & DESIGNATION

1: Desmond McPeake
Senior IHTT Practitioner

2:

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 { }

FAD Penny Dock
14TT

R.E. WESLEY PHILLIPS
CRISIS REFERRAL
FROM WARD 3
PHH

Adult Mental Health – North East Area Crisis Team Referral

CHI N°	0502823496	Carefirst N°		PIMS N°	
*Surname	PHILLIPS	Preferred Name	LESLEY		
*First Name	WESLEY	Alias			
*Address & Post Code	FLAT 0/1 51 THRUSHCRAIG CRECENT, PAISLEY, PA2 6PP				
*Telephone N°	07804144086	*Mobile No.			
*Date Of Birth	05/02/82	*Gender	MALE		
Spiritual Needs	NOT KNOWN	Ethnicity	WHITE	Need for Interpreter	NO
G.P.	DR. JOHNSTONE	Telephone	0141 889 3732	Fax	
Address & Postcode	THE BARONY PRACTICE, NORTH CROFT STREET, PAISLEY				
N.O.K.	NONE GIVEN	Relationship		Tel/Mobile	
Address & Postcode					
Marital Status	SINGLE	N.I Number		Occupation	UN-EMPLOYED
Dependants	NONE			Referral Date	27.12.13

Needs	LESLEY REQUIRES SUPPORT IN THE COMMUNITY DUE TO HIS SHORT ADMISSION TO HOSPITAL. LESLEY IS CURRENTLY SUFFERING FROM LOW MOOD AND HAS SOCIAL STRESSORS AS HE HAS BEEN GAMBLING A LOT RECENTLY. LESLEY STATES THAT HE HAS A BEREVEMENTS RECENTLY INCLUDING HIS EX-GIRLFRIEND JUST HAVING A MISCARRIGE AND ALSO HIS FRIEND DYING THREE WEEKS AGO. LESLEY ALSO STATES THAT IT IS ALSO THE ANNIVERSARY OF HIS MOTHERS DEATH COMING UP.
-------	---

Interventions Required	SUPPORT IN THE COMMUNITY TO TALK ABOUT HIS THOUGHTS AND FEELINGS ENSURE MEDICATION COMPLIANCE
------------------------	---

**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

Diagnosis of personality disorder.
Previous to admission - jumped in front of taxi - No injuries.
History of DSH - scars on arms.
Hanging & overdose attempts.
- Not reported any thoughts of self harm or suicidal ideas prior to his discharge.

CLINICAL

Violence

Several admissions to prison.
Shop robberies with weapons,
and BOP.

Other Risk Factors

Impulsive behaviour
Claimed he cannot keep himself
Safe "He will find a way"

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:

A Campbell

Signature:

A Campbell

Designation:

SI

Date & Time:

24/12/13 21-35

FAD Penny Dock
14TT

R.E. WESLEY PHILLIPS
CRISIS REFERRAL
FROM WARD 3
PHH



Medical Assessment
Parkhead Hospital

Patient Name: **WESLEY PHILLIPS**CHI Number: **0502823496**

Date of Birth:

Address: **012 51 THAMMUNER CROFT****PAZ GPP**

(Or affix patient label)

DATE	TIME	NAME & GRADE OF ASSESSOR	LOCATION OF ASSESSMENT
24/12/13	2020	MACKENIE, GPSTL	PARKHEAD, 3.

GP DETAILS	LEGAL STATUS (AT ASSESSMENT)
	INFORMAL ☒ EDC ☐ STDC ☐ CTO RECALL ☐ OTHER ☐

SOURCE & REASON FOR REFERRAL
Referral from ATE at CRA - voices + suicidal ideation.

PRESENTING COMPLAINT & HISTORY OF PRESENTING COMPLAINT
③ Depressed for a couple of weeks, getting steadily worse. - struggling in books, no signif. debt, no energy, no sleeping. - no appetite, poor concentration. - family have fallen out of him - thoughts of suicide over past 2/52. hang himself, oo - feeling paranoid - been thinking people are after him. Seem to have some insight this with the case. - Best friend died 3/52 ago - Girlfriend had recent miscarriage. - Anniversary of mother's death - has guilt re her death.

MEDICAL ASSESSMENT

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Patient Name :

CHI Number:

PAST PSYCHIATRIC HISTORY (including previous self-harm/CP treatment/admissions/detentions etc.)

- Depression - since aged 16.
 - several admissions to 4 hospitals over the years.
 - last admission to Levensdale 2009
- Personality Disorder (Borderline & ? antisocial tendencies). - diagnosed at 17 yrs
- multiple ODs, cuts to arms, tried to hang himself.
- Attends Dr McMahon at Renfrewshire drug service.

PAST MEDICAL HISTORY (including previous head injuries/seizures/delinium/tremors/recent falls etc.)

ADHD, ? Tourette's,
Ex-IVDA - not for several months.

CURRENT MEDICATION (including compliance/side-effects/drug allergies etc.)

Methadone 50mg OD

NKDA.

Sertaline 150mg OD

- prev on Serenel/Hydroxal until 8/12 ago.
 - required ECG monitoring.

FAMILY HISTORY (including mental illness/suicide/addiction/cardiovascular history etc.)

Uncle - Depression,
Cousin - drug addiction

MEDICAL ASSESSMENT

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Patient Name :

CHI Number:

FORMULATION

③ Hx of PP and depression c multiple episodes 15M/suicide attempts. ↑ social
 Shoreside recently c ↑ suicidal ideation. Cannot guarantee
 own safety

DIFFERENTIAL DIAGNOSIS

- 1) Crisis in acute c PD.
- 2) Depression

RISK TO SELF AND OTHERS

Glasgow Risk Screen Completed ☐

INITIAL TREATMENT PLAN

OBSERVATION LEVEL & MENTAL HEALTH ACT STATUS

Disposal: Discharge ☐ Admit ☒ Short crisis admission

Mental Health Act Status: informal

Time Out: escorted for
cigarettesObservation Level: Special ☐ Constant ☐ General ☒

INTERVENTIONS (including drug treatment / kardex / alcohol detox, etc.)

Medication Plan: regular meds

Kardex Completed ☒Medications Checked with GP ☐Physical Examination Completed ☐Admission Bloods ☐Discussed with senior or reason not to ☒ N Dr Ruiz

Discussed with Crisis or reason not to Y/N

FURTHER INFORMATION / INVESTIGATIONS REQUIRED (collateral history / urine for drug screen or culture etc.)

Own metradax Brought into department.

SIGNATURE OF ASSESSOR

MAGGIE GLEN

MEDICAL ASSESSMENT

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Patient Name :

CHI Number:

Mini-Mental State Examination

(adapted from Folstein et al, Psychiatry Res, 1975)

Maximum

Score

Orientation

5

()

What is the (year) (season) (date) (day) (month)?

5

()

Where are we (country) (city) (part of city) (hospital) (floor)?

Registration

3

()

Name 3 objects: 1 second to say each

Repeat until he/she learns all 3. Number of Trials : _____

Attention and Calculation

5

()

Serial 7's or spell "world" backwards

3

()

Recall

Ask for the 3 objects repeated above

Language

2

()

Name a pencil and watch

1

()

Repeat the following "No, ifs, ands or buts"

Follow a 3-stage command:

3

()

"Take the paper in your hand, fold it in half, and put it on the floor"

Read and obey the following

1

()

CLOSE YOUR EYES

1

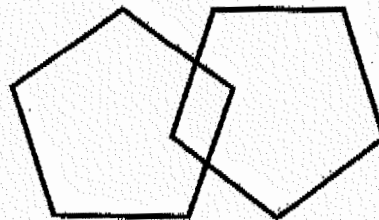
()

Write a Sentence

1

()

Copy the design shown



Total Score

()

out of 30

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
27/12/13	<u>MEDICAL</u> pt seen in ward 3. I note re on admission. He tells me his brother & father fell out with him on Mon/Tues. He was due to give Ram money he owed Ram but as soon as he got his benefit he spent it all gambling. They were angry as this has happened repeatedly & they both told him he was a waste of space & they wanted nothing to do with him. Numerous social problems - opiate dependence - benzocaine dependence, buys about 20 x 10 mg tabs every 2 days, ran out on Mon & felt awful. - gambling habit - conflict with family because of gambling. - separated from girlfriend few months ago. - 7th anniversary of mother's death soon - has coped badly & losing her. He is quite articulate & forthcoming at 10. Reports some nightmares recently about past traumas. Says at times when more stressed, hear "voices in my head". Describes these as "insistent" but struggles to describe them. Are inside his head - he knows they are not real. They say things like he is a waste of space, they speak him. Sound more like post traumatic	

NHS GREATER GLASGOW & CLYDE - MENTAL HEALTH CARE PLAN

CHRONOLOGICAL ACCOUNT OF CARE

PIMS No/CHI No:	LABEL	WARD:	3
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
27/12/13	phenomena rather than part of psychotic illness. No other psychotic symptoms. Nursing staff report that he has looked quite settled on the ward. Has not looked particularly low in mood. Although he reports going without food for long periods he is overweight. No suicidal thoughts expressed to n. staff nor to myself. He does not require to be in hospital any longer -- This seems a social crisis. He is happy in being discharged I have referred him to LHTT (Crisis services) in Paisley. Details given over phone to Kenny Doch. He would like as much written up as possible faxed to 0141 618 5381 Reg will see him tomorrow between 2-3 pm	

 M4son
 CCP-CAC-220506

Adult Mental Health – North East Area Crisis Team Referral

Patient/Carer's View/Understanding of Interventions

LESLEY IS AWARE THAT HE HAS BEEN REFEREED TO THE CRISIS SERVICE.

Alerts (e.g. allergies, history of violence)

SHOP ROBBERY, WEAPONS INVOLVED. HISTORY OF DSH, OVERDOSE ATTEMPTS

Medication at Time of Referral

Name	Dose	Route	Frequency
1. METHADONE	50MLS	P.O	DAILY
2. SERTRALINE	150MG	P.O	DAILY
3.			
4.			
5.			
6.			
7.			
8.			

Medication Compliance/Reasons For Non-Compliance

COMPLIANCE OF MEDICATION UNKNOWN

Accommodation Type	FLAT	Tenure Type	rented
Landlord Details	UNKNOWN	Controlled Door Entry	NO ☐
Household Composition	FLAT 0/2		
*Known Risk Issues			

Completed by: CLAIRE WATSON

Name:

Designation: STAFF NURSE

Signature:

Date: 27.12.13

**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								
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

Diagnosis of personality disorder.
Previous to admission - jumped on
front of taxi - No injuries.
History of DSH - scars on arms.
Hanging & overdose attempts.
- Not reporting any thoughts of self harm or
suicidal ideas prior to his discharge.

~~CLARENCE~~

Violence

Several admissions to prison.
Shop robberies with weapons,
and BOP.

Other Risk Factors

Impulsive behaviour
Claimed he cannot keep himself
Safe "He will find a way"

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:

A Campbell

Signature:

A Campbell

Designation:

S/R

Date & Time:

24/12/13 21-35

CHRONOLOGICAL ACCOUNT OF CARE

PIMS No/CHI No:		WARD:	
NAME:	Wesley PHILIPS		
ADDRESS:	05.02.82 - 3496		
POST CODE:			
DOB & GENDER:			

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

DATE &
TIME

28/12/13 - Attempted h/v by writer and 2¹⁵pm colleague Wendy Mitchell as arranged. no answer & buzzer system. Attempted to call mobile nos, no availability. Agreed to staff to call Parkhead hospital for up to date idea of his nsh on d/c. Spoke to staff, no concerns highlighted. Documented Mr Mason that no nshs on d/c from ward. Given alternative telephone number to try.

2³⁰pm, Called alternative mobile no, Wesley available. At friends home, both he and friend sounded intoxicated. Denied any nshs, apologised for not being at home for visit earlier today. Agreed to v/v tomorrow @ dad's address
2/1, 24 Clarence St
Seedhill

Plan h/v 29/12 @ dad's 11-12pm

Wesley Philips
SR (NHS)

WESLEY PHILLIPS 050282-3496

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
CONT 30/12/13	WESLEY'S PHARMACY AND ASK THEM TO GIVE HIM OUR APPOINTMENT FOR TONIGHT BETWEEN 6-7PM. AND AN APPOINTMENT FOR HIM TO SEE MARGARET ON THE 06/01/14 AT RDS @ 11AM. EXPLAINED TO MARGARET IF WESLEY FAILS TO ATTEND HIS CARE WILL BE TRANSFERRED BACK TO RDS. <i>AKKOLLY</i> AICELLY SEN PRAC	E. Russeu E. Russeu SUPPORT WORKER
30/12 16 ³⁰	PATIENT PRESENTED AT C/C AT 16 ³⁰ ON MONDAY 30TH. DISCHARGED FROM PARKHEAD HOSPITAL ON FRIDAY 27TH ATTEMPTS MADE TO CONTACT PATIENT OVER THE WEEKEND, APOLOGIES GIVEN BY PATIENT AS HE WAS STAYING WITH A FRIEND. TODAY APPEARED SWEATY/ TREMULOUS, STARING EYE CONTACT, VERY MALODOROUS, UNSHAVEN, DISHEVELLED. REPORTS LOW MOOD PRIOR TO HOSPITAL ADMISSION DUE TO SOCIAL STRESSORS AND ANNIVERSARY OF MUM'S DEATH (7 YRS AGO), ALSO EX-GIRLFRIEND HAVING A MISCARRIAGE AND A FRIEND DIES IN THE LAST MONTH. FURTHER TO THIS FEELS ISOLATED, LITTLE FAMILY SUPPORT DUE TO 'GAMBLING ISSUES/DEBTS'.	

2 alcohol

last PIC tomorrow:

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - ~~NURSING~~

CHI: 0502823496

Phillips Wesley
17 Abercorn Street,
PAISLEY,
Renfrewshire
PA3 4AA

D/1808520/2 Male

Date & Time		Signature, Print Name & Designation
	09.15 T/C TO WESLEY; WESLEY AWAKE	
31/12/13	TEAM MEETING ^{ERROR} AND HAS AGREED	
09-35	TO ATTEND MEDICAL REVIEW.	E. Russell
09-35	TEAM MEETING.	E. Russell
	MEDICAL REVIEW TODAY AT CHARLESTON	SUPPORT WORKER.
	CENTRE @ 10.30.	W Mitchell
31/12/13	Seen at i/centre - K. Homan/Myself -	
	AX, recent Pw/thead adm note (photocopy)	
	+ RDS correspondence seen.	A: private dep -
		? personality disorder.
	"I'm alright & people"	Low mood.
	less so alone.	
	continues to c/o struggling &	
	"motivation" - longer standing.	
	Also poor sleep - again longer standing.	
	Advised that ECG is being	
	monitored (I had seen in notes)	
	+ keen to recommence antipsychotic	
	know that RDS will address.	
	various stressors - miscarriage, issues	
	& ex, mum's anniversary pending	
	next week, poor relationships &	
	dad.	
	little routine.	
	Accepted food voucher + intends	
	to use.	
	Admits he has struggled & lack	
	of structure out of prison.	
	conc - ok at i/v.	
	Some guilt re mum's death.	

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
	any since d/c. understanding importance	
	At times misses med ^s .	
	msay tall 5'8. Heavy build Hair uncombed Clothes clean. Spoke slowly - little information. Some elaboration Same reactivity. subj: low. obj: some evidence of low mood, likely in context stressors + longer term personality issues. Internal voices - intermittent. Insight - yes.	
	<u>0/10</u>	
	help seeking. given crisis card.	
	given food voucher.	
	S/w him re recognizing that the next week will be challenging given anniversary. Planning for this proactively - eg already knows will put flowers on mum's grave. Recognizes by service of different period; support available	

WESLEY PHILLIPS 050282.3496.

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
02/1/14 10.05	T/C TO WESLEY STILL NO RESPONSE WILL DISCUSS AT TEAM MEETING WITH MEDICAL STAFF.	E. Russell E. Russell SUPPORT WORKER.
		DR J STEWART 1/17 SENIOR PRACTITIONER
2/1/14 (13.35)	TEXT MESSAGE TO LANDLINE FROM WESLEY RETURNED CALL TO WESLEY REPORTED NO CONCERNS Happy for next contact 3/1/14 12PM AT CHANTEMUN (ENACE - Busy with family & seeing friends Agreed to attend appt -	DR J STEWART 1/17 SENIOR PRACTITIONER
3/1/14 (09.10)	TEAM MEETING. Mental Health Summary Wesley discussed reviewed by DR MC AREE ON THE 31/12/13 - Difficulties contacting Wesley over the weekend however Wesley made contact yesterday Wesley for review today 12PM at CK y appropriate reduce to 22 RDS. Appt - 6/1/13 - Plan - Contact RDS re time of appt for 6/1/13 -	DR J STEWART 1/17 SENIOR PRACTITIONER

Date Assessed: 2 5 1 0 1 4 Time of Assessment: (24 Hour Clock) 1 2 3 0

Personal Details

Surname	Phillips	CHI Number	0502823496
Forename & Initial	Wesley	Marital Status	Single
Previous Name(s)		Legal Status	Review Date: / /
Date of Birth	05.02.82	Advanced Statement	Yes No
Address	0/2, 51 Thrushcraigs Cr	Named Person	
Post Code	Paisley PA2	CPA	Yes No ☒
Telephone No.		Religion	Christian - 6 month - High Hall
Mobile No.	07804144086	Present Occupation	Yes No ☐
	07 847 292 196	Interpreter Required	Yes No ☐
		Adult at Risk AP1 Form	Yes No ☐
Risk to Staff: Focus on Mubong ☐			
Next of Kin		Resides with	Lives alone
Relationship		Relationship	
Address		Tel No.	
Post Code		Consent to Involve	Yes No ☐
Telephone No.		Dependants: Names	DOB
Mobile No.			
Consent to Involve	Yes No ☐		
Height	6ft	Hair Colour	Light brown
Weight	18 stone	Eye Colour	Blue
Build	Heavy	Distinguishing Marks	Tattoo on right forearm, DSH scars, RANCAH UNION JACK
Sex	Male Female	General Appearance	CASUAL
Allergies	NIL	Driving	Yes No ☒

REFERRED BY (Name) :- Dr Kamyra

& AGENCY/DESIGNATION :- Ward 10, RAH

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:		
ASSESSED BY -		
NAME	FM CR	NAME
		INTERVIEWER

**ADULT EMERGENCY ASSESSMENT
DYKEBAR HOSPITAL**

Existing Services involved in care (next appointment due)	
GP: Dr Johnston, Barony MP, Paisley	Psychiatric Consultant: Dr McMahon
	Renfrewshire Drug Service: NOT INVOLVED
Telephone No: 0141 889 3732	Telephone No: WITH ROS SAME 15/8/14
Social Worker:	CPN:
Telephone No:	Telephone No:
Other: Margaret Parkinson, RDS Worker	Other:
Telephone No: 0141 889 1223	Telephone No:

PRESENTING PROBLEMS AND ASSESSMENT OF RISK

(as expressed by client/carer and assessor):

32yr old man. 24/10/14 4:30 AM
 Referred by WCC RAM - patient admitted following overdose of £30
 Heroin injected at 11PM - previous night - following this 2hrs later
 at 1AM alleged took 30 paracetamol. He then informed his friend
 he had taken an overdose of 50 paracetamol - who then phoned
 services. Informed he had vomited after overdose - paracetamol level
 (135) 4 hour post overdose. Now off parvolex treatment. Obs normal
 No end of life planning - no note. LFTS normal
 UTE normal
 Was stating he feels off to manage, medication would help.
 Was asking to be linked in with RAM-H. to
 give him some routine.
 Finds himself sleeping most of the day - gambling at the
 bookies - future focus re involvement with services.
 States overdose was not intent to kill himself did not inject
 into his vein. States feeling depressed / lost few days - hearing voices
 telling him he was worthless - "wasting his life gambling".
 States he believes in God - he talks to him to keep himself safe.
 No current suicidal thoughts - feels safe enough to go
 home. Action was a 'cry for help' involvement with services

**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):

Previous Admissions to Levensdale, Parkhead, Stobhill,
Innochlyde, RHH-32...

Seen by Psychologist since aged 7.
Diagnosed with Tourettes disorder and with emotionally unstable personality.
Currently attends RDS. Finished RDS Sept.
Previous overdoses and to self harm
Assessed by IHTT in past.

Last admission
Xmas 13 to Parkhead.

CURRENT MEDICATION

NAME	DOSE	FREQ	CURRENT	OTHER INFO
Sertraline	150mg	Daily	5PM -	Months script.s. - 1 year.
Methadone	50mls	Daily		Months Supply.
Aripiprazole	5mg		5PM -	On for 1 year.
				Managed by GP.

ATTITUDE TOWARDS MEDICATION (including history of concordance):

Not taking Anti-depressant regularly forgets to take them
Past non concordance with medication. Collects daily from local pharmacy.
Misses Aripiprazole.

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

Irregular ECG in past.
Ex IV drug user.
HEP - C +ve

ADULT EMERGENCY ASSESSMENT
DYKEBAR HOSPITAL

MEDICINES RECONCILIATION

Source (please tick all used)

[illegible]

Pharmacy comments:

**ADULT EMERGENCY ASSESSMENT
DYKEBAR HOSPITAL**

FAMILY HISTORY (including family, education, occupation, parental/siblings relationships, childhood trauma):	
Mother	Died in 2007.
Father	Parents separated in 2002.
Siblings	Has 2 older brothers [REDACTED]
Children	None.
Family Psychiatric History	[REDACTED]

PERSONAL HISTORY	
Birth / Childhood	Born in Germany, returned to Glasgow aged 2. Happy childhood.
School / Education	Suspended from school due to short temper. Expelled aged 14.
Primary/ Secondary Qualifications	
Occupations	Spent in care home or parents – not coping.
Relationships (including psycho sexual)	Single.
Premorbid Personality	Reports he is a good person.

ADULT EMERGENCY ASSESSMENT
DYKEBAR HOSPITAL

SOCIAL CIRCUMSTANCES
ACCOMMODATION and FINANCES: Lives in Homeless supported accommodation in Thrushcraigs. - 2 yrs. Receives DLA and ESA. * Money due this Thursday. No debts
OCCUPATIONAL and DAYTIME ACTIVITIES: Spends most of day sleeping. - Follows football. Then goes to the Bookies - Spends most money in bookies. PLAYING PATTES
PERSONAL CARE and DAILY LIVING SKILLS: A little unkempt. Not attending to R.H. regularly.
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): Father is supportive 
ALCOHOL and ILLICIT DRUG USE (current and past, previous detox programmes/seizures, Methadone, IV use, cigarette smoking, misuse of prescribed medications) Long history of Polysubstance misuse. - Reports no use of illicit at present other than for overdose. Swapped drug addiction for gambling addiction.
FORENSIC HISTORY (past and present) Charged with carrying an offensive weapon. Served 18 months of a 3 year prison sentence. Released on supervised order in 2011 due to expire next year. Charged with breach of the peace and resisting arrest. Admitted to committing 2x robberies. Low Moss Prison - June - shoplifting/assault - 6 months. - released Sept. Stopped Methadone while in prison.

ADULT EMERGENCY ASSESSMENT
DYKEBAR HOSPITAL

MENTAL STATE EXAMINATION

APPEARANCE & BEHAVIOUR:

Unkempt, malodorous, a little unkempt.

Co-operative - reactive, good eye contact, reasonable rapport.

MOOD & AFFECT (Objective & Subjective):

Subjectively - Relates mood 5 out of 10 - improved over last 48 hours

Objectively - Euthymic - reactive affect - spontaneous use of humor.

SPEECH & THOUGHT FORM:

Speaks clearly -

No formal thought disorder.

THOUGHT / CONTENT

More hopeful - sees a future of services help.
No current suicidal thoughts

PERCEPTUAL ABNORMALITIES:

No voices - since overdose 48 hours ago
Hears voices more often when mood is low.

COGNITION:

Grossly Intact

INSIGHT:

Retained.

INFORMATION GAINED FROM OTHER SOURCES (collaborative information):

CLIENTS EXPECTATION OF REFERRAL/SERVICE (recovery focused):

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

**ADULT EMERGENCY ASSESSMENT
DYKEBAR HOSPITAL**

SUMMARY (including impression, identified strengths and risks):

32 yr old man. Diagnosis of E.U.P.D & poly substance use. Previous methadone programme spent 3 months in prison - released Sept 2014 (assault & robbery) - Came off methadone programme whilst in prison. Since release - mood has deteriorated, No structure to day - has gambled the majority of his money - gambles due to boredom. Took 1/2 of 30 paracetamol & £30 bag of i.v. heroin (prior to 20/10) ~~Heroin~~ No drug use before this. Now has no further S.I. - Wishes to engage w/c services - for structure to his day. Good support from his father + his friends.

RELEVANT STRESSORS:

Gambling. No structure to his day.

PROTECTIVE FACTORS:

His father.

PLAN:

Refer to O.P. psychology (has no involvement w/c services at present)
Refer to R.A.M.U. - Group/group work for some structure to his day.
Crisis number given.
Encourage to engage with Gamblers anonymous.

DISCUSSED WITH:

Dr. GILKES ON call 2nd S.P.A.

Assessors signatures:

[Signature]

PRINT & DESIGNATION

1: B GIBSON	SEN PRACTITIONER
2: E. MCGEE	PRACTITIONER

Mental Health Partnership
Clinical Risk Screening and Management Tool

Service Users Name: Wesley Phillips	CHI N°/DoB:	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 Liaison @ R.A.N.		

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: B. Gibson	Signature: B. Gibson
Designation: sen Practitioner	Date & Time: 25.10.14 13.40

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	✓
S2	Use of violent methods		V2	Use of weapons	
S3	Previous self-harm	✓	V3	Previous admission to secure units	
S4	Socially isolated	✓	V4	Convictions for violence / assault	
S5	Past diagnosis of personality disorder,		V5	Past diagnosis personality disorder or psychopathy	
S6	Major physical illness		V6	Alcohol or drug misuse	
S7	Alcohol/drug misuse		V7	Male under 35	
S8	Family history of suicide		V8	Prior supervision failure	
S9	Previous treatment non-compliance		V9	Previous treatment non-compliance	
S10	Impulsivity		V10	Impulsivity	
Short Term or Precipitating Factors					
S11	Planning suicide		V11	Intoxicated	
S12	Access to lethal method	✓	V12	Acute psychosis	
S13	Hopeless / helpless	✓	V13	Violent fantasies	
S14	Recent major loss		V14	Identified target	
S15	Recent psych hospital discharge		V15	Access to weapons	
S16	Current or recent treatment non-compliance	✓	V16	Current or recent treatment non-compliance	
Protective Factors					
S17	Willing to respond to advice/carers	✓	V17	Willing to respond to advice	
S18	Has close relationship	✓	V18	Appropriate services available	
S19	Religious beliefs				

**Mental Health Partnership
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Please write N/A if no risks identified or no risk management actions required.

Management plan	Action by:
Suicide/Self Harm No S.I. or thoughts of D.S.H. at present Refer to O.P. psychology for monitoring of mood, mental health & med. Refer to R.A.M.U. - for groupwork / structure to his day. Crisis numbers given	25.10.14
Violence Recent jail sentence for shop lifting - wanted to get into jail. Realised that shoplifting wouldn't get him into jail so then assaulted the shop security guard to get what he wanted. *No violence experienced with current presentation	25.10.14
Other Risk Factors Has Has been gambling due to boredom/no structure to his day Encourage to engage with Gamblers Anonymous.	25.10.14

Outcome of screening/management plan discussed with

Service User ☒	Carer ☐	Consultant ☐	Other Dr. ☐
CPN ☐	Ward Nurse ☐	Social Work ☐	Occupational Therapy ☐
Psychology ☐	Pharmacy ☐	Other ☒ specify on call SPR Dr Gilkes	

Management Plan completed by

Print Name: B Gibson	Signature: BG
Designation: Sen Practitioner	Date & Time: 25.10.14 13.40



Renfrewshire
Council

EMERGENCY ASSESSMENT REQUEST

IHTT TELEPHONE REFERRAL



Greater Glasgow
and Clyde

Date of Referral: 03.05.14		Time of Referral: 9.00	
Name: Wesley Phillips	Sex:	DOB: 05.02.82	CHI No: 3496
Home Address: 8 Thomson Brae Paisley		GP: Dr Johnstone Address: Barony MP	
Postcode: PA1 1TP (Postcodes P1-12& P14 acceptable. P13 excluded)		Telephone No:	
Telephone No: (Wrong Number)		Next of Kin/Sig Other:	
Mobile: 07432 134470		Relationship:	
Current Location If Different:		Address:	
		Telephone No:	

Referrer: Maire McCreadie	Agency: OOH CPN	Tel No:
Seen in last 24 hours: YES ☒ NO ☐		
Patient known to psychiatric services: YES ☒ NO ☐ NK ☐		
If yes those involved: ROS		
Legal Status:	CPA (Care Manager):	

Reason for Referral/Current Presentation

More unsettled over past week - using heroin & street
diazepam in this time.

H/O DSH (cutting, overdose, walking in front of traffic) - last self
harm via o/d of paracetamol 2 months ago

Reports suicidal thoughts over past week - listed variety of ways to
DSH but no active plan/intent

Denial of triggers/precipitants

Diagnosis:

F1, F6

Any children at home: YES ☐ NO ☒			
Names:	Gender	D.O.B.	Current location / carer:
History of alcohol abuse: YES ☐ NO ☐ Past ☐ Present ☐ History of drug abuse: YES ☒ NO ☐ Past ☐ Present ☒ 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 ☐ Details: Potentially dangerous to others ☐ CONSIDER ASSESSMENT AT DYKEBAR ☐			
KNOWN FORENSIC HISTORY : YES ☒ NO ☐ Past ☒ Present ☐ Details: <i>PRISON FOR ROBBERY</i> Potentially dangerous to others ☐ CONSIDER ASSESSMENT AT DYKEBAR ☐			
KNOWN HISTORY OF SELF HARM : YES ☒ NO ☐ (<u>Overdose</u> / <u>cutting</u> / other)			
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: <i>SERTRALINE</i> <i>ARIPIPRAZOLE</i>			
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:		Other:	
Allocated assessors:			
INFORMED:			
Reception Staff: YES ☐ NO ☐ Time:			
Duty Dr: YES ☐ NO ☐ Time:			
Signature:	Date:	Time:	

[illegible]

CHRONOLOGICAL ACCOUNT OF CARE

PIMS No/CHI No:	0502823496	WARD:	1HUT
NAME:	Wesley Phillips		
ADDRESS:	8 THOMSON Brae Paisley		
POST CODE:	PA7 1TP		
DOB & GENDER:	05-02-82 (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

5/5/14 - DID NOT ATTEND APPT
(1835) FOR ASSESSMENT - STAFF
LEFT MESSAGE ON MOBILE
NUMBER FOR WESLEY TO MAKE
CONTACT -
CALLED MOBILE NUMBER SPOKE
TO A [REDACTED] PATIENT OF PCMAT
MOBILE NUMBER IT WAS NUMBER
HE DID SEE WESLEY TODAY -
NOT SURE IF HE WILL SEE HIM
AGAIN TODAY - NO OTHER
NUMBER FOR WESLEY -

PLAN - 6/5/14 Discuss with
DR MCAREE - NOT
ENGAGEMENT -

[Signature]
DORCA
1HUT
Senior
Practitioner

6/5/14 TEAM MEETING.

0945 Team unable to make contact with
Wesley since his referral to the team,
friend has seen him and will pass
on message that we have been trying
to get a hold of him. 1HUT to liaise
with RDS and see when they are due
to have contact with him.

[Signature]
J PATTON
Senior 1HUT
Practitioner

NHS GREATER GLASGOW & CLYDE - MENTAL HEALTH SERVICES

[illegible]

CHRONOLOGICAL ACCOUNT OF CARE

PIMS No/CHI No:	AREA:	WARD:
NAME:		
ADDRESS:	West Phillips	
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
8/4/14	Diagnose at Chisholm. taking vitamin at chisholm. no vitamin 3 weeks, as felt this that good vitamin to commit suicide. No heroin. W. Lorraine Tell out - Dad, so back to Dad home gerby deer. Looks very better by - make so crippage 5 Seize 150,	
01/10/14	RDS - one Care - ? take with at a treatment.	U. Ashraf (S.D. PSYCH)
12/11/14	OPR - Dykobaal. DNA Not contacted the services Plan - Opt in letter	
12/11/14	patient had called OPR	SHANAHAN
11.40	at 11.30 am -> starting trial do forget about the appointment requested to be arranged - 10/12/14	

at 9.30 Dykobaal
CCP-CAC-220506
Opr

CHRONOLOGICAL ACCOUNT OF CARE

PIMS No/CHI No:	14861	WARD:	
NAME:	NESLEY PHILLIPS		
ADDRESS:	Flat 011 51 Thrushcraig Cres		
POST CODE:	G56 2 82 34 96		
DOB & GENDER:	Dr Justine, Barry Rautize		

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
8.12.15/	R.D.S.	
HPC/	Was in Dykebar - one week was hearing voices.	
	Has been hearing other voices in the past / been in other hospitals.	
	Previously on Aripiprazole - seen by Dr McMahon.	
	Stopped Methadone, seroquel and Aripiprazole	
	Sept 2014. when in prison.	
	Released Dec	
	March - Christian Rehab Centre in Derby - 4 months	
	18 months rehab, but left early.	
	Started using on release.	
	Using since July	
	Has seen GP - advised to go to RDS. GP refene	
	I.H.T.T. seen at Dykebar.	
	Has been in hometers flat at Thrushcraig.	
	3 weeks ago voices started.	
	Telling him "God wants him"	
	Telling him to hang himself	

CCP-CAC-220506

CHRONOLOGICAL ACCOUNT OF CARE

PIMS No/CHI No:	1 ABFT	WARD:	
NAME:			
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
	Eating + Drinking when in hospital. Nothing when home. Unsettled re risk of overdose. Needs Daily supervision. Clear.	
	CD pulse 70 reg	
	Conin inspected - healing, nil tender.	
	Good peripheral pulse	
	nil other infected injection sites.	
	Needs 3um	
15/10/15	RDS - GP <.	
	- 5 days ago. £ 3x10 bags; injected in groin.	
	- had few OHC Tablets 3/4 days ago.	
	- Valium until prior to Dyhyper admission.	
	- not else N. Kazepe-5-2 mte Cannabis.	
	- 2 weeks.	
	- admits to previous voices. hears them presently.	

Date of Referral: 28.9.15		Time of Referral: 10.40	
Name: WESLEY PHILLIPS	Sex: MALE	DOB: 5-2-82	CHI No: 3496
Home Address: 14F Thrushcraigs Crescent PAISLEY.		GP: DR Johnstone. Address: do Baring practice Paisley	
Postcode: PA2 6PP. (Postcodes P1-12& P14 acceptable. P13 excluded)		Relationship: _____	
Telephone No: _____		Address: _____	
Mobile: _____		Telephone No: _____	
Current Location If Different: _____			

Referrer: MARY	Agency: F.I.R.S.T.	Tel No: 848 9090
Seen in last 24 hours: YES ☒ NO ☐		
Patient known to psychiatric services: YES ☐ NO ☒ NK ☐		
If yes those involved: PREVIOUS MDS - UNKNOWN IF STILL IN CONTACT - DR McMAHON MR PARKINSON (NOW RETIRED)		
Legal Status:	CPA (Care Manager):	

Reason for Referral/Current Presentation

Client self presented to F.I.R.S.T, stated he was suicidal, voices telling him to hang himself. feels unable to stay safe.

CURRENTLY USING STREET DRUGS - HEROIN. 2 UNPRESCRIBED METHADONE

THOUGHTS OF HANGING SELF TODAY BUT SEEKING HELP.

Diagnosis: OPIATE DEPENDANCE F11

ADULT EMERGENCY ASSESSMENT

Date Assessed: 2 8 0 9 1 5 Time of Assessment: (24 Hour Clock) 1 3 2 0

Personal Details

Surname	Phillips	CHI Number	0502823496
Forename & Initial	Wesley	Marital Status	Single
Previous Name(s)		Legal Status	Review Date: / /
Date of Birth	05.02.82	Advanced Statement	Yes ☐ No ☐
Address	14 F. 05, 51 Thrushcraigs Cr	Named Person	
	Paisley	CPA	Yes ☐ No ☒
Post Code	PA2	Religion	Christian
Telephone No.		Present Occupation	unemployed
Mobile No.	07804144086 - no phone.	Interpreter Required	Yes ☐ No ☐
		Adult at Risk API Form	Yes ☐ No ☐

Risk to Staff:

Next of Kin		Resides with	Lives alone
Relationship		Relationship	
Address		Tel No.	
		Consent to Involve	Yes ☐ No ☐
Post Code		Dependants: Names	
Telephone No.			DOB
Mobile No.			
Consent to Involve			

Height	6ft	Hair Colour	Light brown
Weight	18 stone	Eye Colour	Blue
Build	Heavy	Distinguishing Marks	Tattoo on right forearm, DSH scar
Sex	Male ☐ Female ☐	General Appearance	
Allergies		Driving	Yes ☐ No ☒

REFERRED BY (Name) :- First Crisis

& AGENCY/DESIGNATION :-

CONTACT No.-

ASSESSMENT LOCATION: AAU

ASSESSMENT OUTCOME

ADMISSION	YES ☐ NO ☐	CMHT YES ☐ NO ☐
HOSPITAL	WARD	OUT PATIENT REQUEST YES ☐ NO ☐
		IHTT YES ☐ NO ☐

ANY OTHER INFORMATION:

ASSESSED BY -

NAME		NAME	
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ADULT EMERGENCY ASSESSMENT
DYKEBAR HOSPITAL

Existing Services involved in care (next appointment due)	
GP: Dr Johnston, Barony MP, Paisley	Psychiatric Consultant: Dr McMahon
	Renfrewshire Drug Service (no contact for 1yr)
Telephone No: 0141 889 3732	Telephone No:
Social Worker:	CPN:
Telephone No:	Telephone No: [REDACTED]
Other: Margaret Parkinson, RDS Worker	Other: Batel, Epsom Derby, (organised via Life Church)
	4 months rehab March - July 2015
Telephone No: 0141 889 1223	Telephone No: -due to attend Rehab centre in Kilmacolm.

PRESENTING PROBLEMS AND ASSESSMENT OF RISK

(as expressed by client/carer and assessor):

PC / Suicidal ideation

Bad thoughts telling him God wants him to commit suicide.

HPC / No sleep past 13 days due to incessant voices in his head past 2 weeks. Unsuccessful distraction & TV.

'Paranoia' - feels God is setting him up to send him over the edge. Does not feel in danger from other people.

Last injected heroin 24hrs ago (3pm)

Poor appetite.

Poor concentration.

Mood - low. 1/10. 'depressed'.

Sees flashing images of himself hanging - puts this down to lack of sleep.

1 male derogatory voice from inside him telling him he is making God angry ~~voice~~ the

Considering hanging himself or throwing self in front of bus. No protective factors.

Future-focused - planning on taking money out of account tomorrow. Plans for Rehab next month (Haven in Kilmacolm).

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):

Seen by Psychologist since aged 7.

Diagnosed with Tourettes disorder and with emotionally unstable personality.

Currently attends RDS.

- Spent admission*
- Stopped attending RDS 1 year ago.
 - Attended for 4/12 - Kelob in Derby
 - March - ~~Aug~~ ~~20~~ August
 - Awaiting outcome of AA for Kelmacallu HANU

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

Irregular ECG in past.

Ex IV drug user.

Nil current.

ADULT EMERGENCY ASSESSMENT

MEDICINES RECONCILIATION

Source (please tick all used)

Patient ✓	Relative/ Carer	Patient order slip	GP ref letter/ print out	GP ECS	GP phone call	Patient's own drugs	Other
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[illegible]

Pharmacy comments:

Previously: methadone - stopped 9/12 ago whilst in prison

ADULT EMERGENCY ASSESSMENT
DYKEBAR HOSPITAL

FAMILY HISTORY (including family, education, occupation, parental/siblings relationships, childhood trauma):	
Mother	Died in 2007.
Father	Parents separated in 2002. <i>Not spoken since falling out 2/12 ago when left Rehab early completed 4/18 months and resumed drugs)</i>
Siblings	Has 2 older brothers. Anthony – lives in Greenock.
Children	None.
Family Psychiatric History	

PERSONAL HISTORY	
Birth / Childhood	Born in Germany, returned to Glasgow aged 2. Happy childhood.
School / Education	Suspended from school due to short temper. Expelled aged 14/15 <i>claims due to Tourette's.</i>
Primary/ Secondary Qualifications	
Occupations	Spent in care home or parents – not coping. <i>Short-term in building site. Last worked a few yrs ago - can't remember what job.</i>
Relationships (including psycho sexual)	Single.
Premorbid Personality	Reports he is a good person.

ADULT EMERGENCY ASSESSMENT
DYKEBAR HOSPITAL

SOCIAL CIRCUMSTANCES
ACCOMMODATION and FINANCES:
1 bed flat at Thrushcraig for past 2 1/2. Likes flat. No much 2 neighbours. Denies debt or financial issues. Benefits - ESA (£250) + PLA (£400)
OCCUPATIONAL and DAYTIME ACTIVITIES:
Unemployed. Sits around in friends' houses, takes illicit drugs.
PERSONAL CARE and DAILY LIVING SKILLS:
Degree of self-care. Flat quite messy.
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):
Henry Moody - support worker
ALCOHOL and ILLICIT DRUG USE (current and past, previous detox programmes/seizures, Methadone, IV use, cigarette smoking, misuse of prescribed medications)
Started smoking heroin age 14, then injecting. Also crack. Currently heroin IV past 2 months, £30/day. Street valium 10 cigarettes/day. Denies alcohol.
FORENSIC HISTORY (past and present)
Charged with carrying an offensive weapon. Served 18 months of a 3 year prison sentence. for armed robberies 2009 (21 out of 42 month sentence) Released on supervised order in 2011 due to expire next year. Charged with breach of the peace and resisting arrest. Admitted to committing 2x robberies. Current charge for shop-lifting + possession of heroin (1/8 - £100) - due in court November 2015.

ADULT EMERGENCY ASSESSMENT
DYKEBAR HOSPITAL

MENTAL STATE EXAMINATION

APPEARANCE & BEHAVIOUR:

Slightly malodorous, tall overweight gentleman, slightly dishevelled dressed in leasurewear. Good eye contact. Suspicious, Anxious

MOOD & AFFECT (Objective & Subjective):

Subjectively - Low, depressed. mood '10.
Objectively - Flat. reactive.

SPEECH & THOUGHT FORM:

No issues in speech. No ITD.

THOUGHT / CONTENT

Thoughts of killing self, difficulty coping in voices telling him to kill self.

PERCEPTUAL ABNORMALITIES:

Auditory hallucinations - one male derogatory voice telling him God wants him to kill self

COGNITION:

Orientated T ✓ P ✓ P -

INSIGHT:

Accepts that God unlikely wants him dead. self-presents to mental health services as requires help in mental health.

INFORMATION GAINED FROM OTHER SOURCES (collaborative information):

CLIENTS EXPECTATION OF REFERRAL/SERVICE (recovery focused):

I don't know - wants reassurance that voice not from God. wants to achieve better lifestyle

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

ADULT EMERGENCY ASSESSMENT
DYKEBAR HOSPITAL

SUMMARY (including impression, identified strengths and risks):

33 → EUPD
current opiate misuse (10 heroin daily)
2/52 w/ suicidal ideation & low mood & anore. poor sleep,
appetite and concentration. Reports hearing one derogatory
male voice telling him God wants him to die. Plans to
hang self w/ rope or throw self in front of vehicle. Not
actively responding to hallucinations. Last injected
heroin 24hr ago.

RELEVANT STRESSORS:

Voices telling him God wants him dead
Court case in Nov 2015.

PROTECTIVE FACTORS:

Denies any.

PLAN:

Admit informal (gen obs) (pam bed on south).
Bloods
Physical
ECG
Kardex

DISCUSSED WITH: Gillian Howieson

Assessors signatures:  Thomson

PRINT & DESIGNATION

1: Kirsty Thomson CTB

2: George Mend ~~HAT~~

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 { }

NHS Greater Glasgow & Clyde

Admission Form/SMR04 Data Form

Part 2 To be filed in patients Health Records

PATIENT DETAILS	CHI Number/DOB		0502123496								Under 18 Y/N	
	PIMS Number (Glasgow only)											
	Surname		PHILLIPS									
	Forename		WESLEY									
	Home Address		14F The Village								Home Tel:	
	Post Code		PA2 6PP								Mobile Tel: 07304144051	
Sex		Ethnic Group (Mandatory - See back for codes)								Marital Status		
Male/Female		IA								Single		
Next of Kin	Name		Alexander Phillips								Named Person or other Contact Details if Different from N.O.K.	
	Address		241-24 Clarendon									
	Post Code		Unknown									
	Home Tel											
	Mobile Tel		07349110105									
	Relationship		Father									
	Is NOK to be Involved/Informed of Care?		Y / N								Is Contact to be Involved/Informed of Care? Y / N	
GP Name/ Address	GP Name		Dr. Telford								Telephone Number	
	Address		Rugby Medical Practice								0141 887 3132	
Admission/ Referral Details	Date	Time of Arrival on ward (24 Hr)	Consultant	Ward	Admitted/Transferred From	Admission Reason						
	25/10/15	15.00	Dr Banno	H South	Home	5239						
See Back Cover for Codes	Name of Admitting Hospital	Referred by:	Previous Psychiatric IP care: Yes / No If Yes Name of most recent Psychiatric Hospital					Admission Type				
	Dykebar Circus	Fred						39				
Legal Status	FORMAL / INFORMAL If FORMAL Section Detail		Diagnosis		1. Diagnosis on Admission							
	Informal		EUPD Anxiety Depression		2. Other Conditions							
Discharge Details	Date	Time (24hr)	Discharge Type		Discharge to							
	25.10.15	11.40	II		II							
	Consultant on Discharge				Ward on Discharge							
	Type of Psychiatric Care Provided		Aftercare Arrangements		Legal Status on Discharge							
	3		1		Informal							
See Back Cover for Codes	1. Discharge on Diagnosis		Care Programme Approach Y/N									
	2. Other Conditions											
	3. Other Conditions											

Completed by CP/10

Signature

ADMISSION INFORMATION

CHIN ^o :	0502823496	WARD:	Scdlz
NAME:	Wesley Phillips		

ADMISSION DETAILS

DATE OF ADMISSION:	28.9.15	TIME ADMITTED:	15.00
ADMITTED FROM:	Home	ACCOMPANIED BY:	Fird. crisis
CONSULTANT:	Dr. Benne	SHO/REGISTRAR:	
NAMED NURSE:	Ben Cullen	MHO	
ASSOCIATE NURSES [INCLUDING NIGHT STAFF]	Denise Gallagher		
CARE MANAGER	Jim Smith		
MENTAL HEALTH ACT/CRIMINAL PROCEDURES ACT STATUS ON ADMISSION	Informal		
CARE PROGRAMME APPROACH STATUS ON ADMISSION	Not on CPA		
EG. NOT ON CPA/ ON CONTINUING CARE PROGRAMME/ ON SEVERELY AT RISK PROGRAMME			

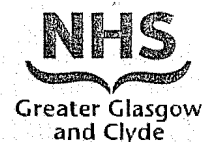
CLINICAL OBSERVATIONS ON ADMISSION

BLOOD PRESSURE:		PULSE		TEMP	
ROUTINE URINE SPECIMEN					
WAIST CIRCUMFERENCE					
OXYGEN SATURATION		RESPIRATORY RATE			

PHYSICAL DESCRIPTION

HEIGHT:		WEIGHT:		WALKING AID OR PROSTHESIS:	No
COMPLEXION:		HAIR COLOUR/STYLE:			
EYE COLOUR:		SPECTACLES/CONTACTS		No	
DENTURES:	No	BMI:			
HEARING AID:	No	BUILD:			
DISTINGUISHING FEATURES: [TATTOOS, SCARS, BIRTHMARKS, PIERCINGS, ETC.] PLEASE DESCRIBE AND GIVE LOCATION					
STAFF ALERTS G. HISTORY OF VIOLENCE/SELF HARM, HOME VISIT INSTRUCTIONS					

In-patient Services Child Information Gathering Form



Name: Wesley Phillips	DOB: 5.2.82	CHI: 3496
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Do you have or are you caring for any children under the age of 18 years? Yes ☐ No ☒

Name of Child 1:	Address: If different to person being assessed
Date of Birth:	
Child Protection Register / Supervision	
☐ Yes ☐ No	

Name of Child 2:	Address: If different to person being assessed
Date of Birth:	
Child Protection Register / Supervision	
☐ Yes ☐ No	

Name of Child 3:	Address: If different to person being assessed
Date of Birth:	
Child Protection Register / Supervision	
☐ Yes ☐ No	

Name of Child 4:	Address: If different to person being assessed
Date of Birth:	
Child Protection Register / Supervision	
☐ Yes ☐ No	

Name of Child 5:	Address: If different to person being assessed
Date of Birth:	
Child Protection Register / Supervision	
☐ Yes ☐ No	

Agencies Involved

- | | |
|--|---|
| Social Work Child & Families Team ☐ | Mental Health Practitioner ☐ |
| Health Visitor ☐ | Other (please specify below) ☐ |
| School/Nursery ☐ | None ☐ |

Child Name	Contact Name	Professional Title	Telephone Number

Where are your children and who are they staying with during your admission to hospital?

Do you have any concerns about the arrangements for your children while you are in hospital?

Greater Glasgow & Clyde Health Board
Renfrewshire Division

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

No belongings.


Date:

28.9.15

Patient's Name _____

Chi No./unit No.: _____

Clinical Area _____

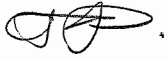
PIMS No/CHI No:	0502823496	WARD:	Scotty
NAME:	Wesley Phillips		
ADDRESS:	14F Thrushcraigs Crescent		
POST CODE:	PA2 6PP		
DOB & GENDER:	5.2.82 (M)		

[illegible]

6. FULL UNACCOMPANIED:

CLINICAL OBSERVATION REVIEW RECORD

PIMS No/CHI No:	0502823496	WARD:	South
NAME:	Wesley Phillips		
ADDRESS:	14 F Tzurdzaraigs Crescent		
POST CODE:	PA2 6PP		
DOB & GENDER:	5.2.82 (M)		

DATE	OBSERVATION LEVEL	REASON CODE	NO. OF STAFF REQUIRED	SPECIFIC CONDITIONS TO OBSERVATIONS	NAME OF DOCTOR INVOLVED IN REVIEW	NURSE SIGNATURE	REVIEW DATE
28.9.15	Gen	—	—	Hardy safety checks	Dr Bernie		

Reason Codes: 1. Self Harm: 2. Suicide: 3. Aggression: 4. Wandering: 5. Unpredictable Behaviour: 6. Accidental Injury:
7. Off-site: 8. Otherplease specify

Greater Glasgow and Clyde

PIMS No/CHI No:	050282 3496	WARD:	500th
NAME:	Wesley Philips		
ADDRESS:	11F Throscrofts Crescent, Pasley		
POST CODE:	PA2 6PP		
DOB & GENDER:	050282 (m)		

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
28.9.15	Nursing - Wesley was admitted to South ward following contacting First Crisis voicing thoughts of harming himself due to command hallucinations. He has been admitted on an informal basis and being nursed on general observations. Orientated to ward and layout which he was settled with. Accepting of evening meal and spending time around ward. Approached staff stating he is struggling read notes he has been using £30 a day of heroin. Telephone prescription of once only 3mg Diazepam however when staff went to administer this he was sleeping. No concerns to note.	GJ/dps GJ/dps

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
20/9/15 0640	<u>Flight Nurse</u> Lesley has yet to be written up for dihydrocodiene detox. L has given discretionary 1mg Lorazepam and dihydrocodiene 30mg as alternative medication at 22.00 hours. No overt signs of opiate withdrawal last night although did request medication stating he was anxious/agitated.	⑥ D. J. [Signature]
ORAL AS REQUIRED PSYCHOTROPIC MEDICATION MONITORING Date <u>20/9/15</u> Time given <u>22:00</u> Medication & Dose Given: <u>Lorazepam 2mg</u> Initiated by: <u>[Signature]</u> Patient request ☒ Nurse ☐ Medical ☐ Reason for Administration: <u>Reported agitation</u> Restraint occurred?: Yes/No Datix required: Yes ☐ Number <u> </u> No ☒ Sign <u>[Signature]</u> Print <u>[Signature]</u> Designation <u>Senior Nurse</u> Ensure 30-60 minute review is completed and signed on <u>every</u> occasion Patient review 30-60 minutes after administration (tick) Much improved ☐ Slightly improved ☒ No change ☐ Worse ☐ Sign <u>[Signature]</u> Print <u>[Signature]</u> Designation <u>Senior Nurse</u> Time <u>23:00</u>		
ORAL AS REQUIRED PSYCHOTROPIC MEDICATION MONITORING Date <u>20/9/15</u> Time given <u>22:00</u> Medication & Dose Given: <u>Dihydrocodiene 30mg</u> Initiated by: <u>[Signature]</u> Patient request ☒ Nurse ☐ Medical ☐ Reason for Administration: <u>Reported agitation</u> Restraint occurred?: Yes/No Datix required: Yes ☐ Number <u> </u> No ☒ Sign <u>[Signature]</u> Print <u>[Signature]</u> Designation <u>Senior Nurse</u> Ensure 30-60 minute review is completed and signed on <u>every</u> occasion Patient review 30-60 minutes after administration (tick) Much improved ☐ Slightly improved ☒ No change ☐ Worse ☐ Sign <u>[Signature]</u> Print <u>[Signature]</u> Designation <u>Senior Nurse</u> Time <u>23:00</u>		

CHRONOLOGICAL ACCOUNT OF CARE

PIMS No/CHI No:	0502823496	WARD:	South
NAME:	Wesley Phillips		
ADDRESS:	147 Thorncliffe Road, Ardrossan, Paisley		
POST CODE:	PA2 6PP		
DOB & GENDER:	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
29/9/15 0600	Wesley has now been written up for Elexon regime - dihydrocodeine. Appen to have had positive effect from discretionary medication. Slept throughout.	[Tig] (6)
29/9/15	Ward round: Dominique McGilroy, med student; Sozia Burke, pharmacist; Ulrich Fischer, clinical psychologist; Camille Phelps, S/N; P. Benke. - Confirms that he restarted IV heroin, \$30 per day, about 2 months ago. - Voice telling him God wants him dead for past two weeks. Tried to hang himself at home with a sheet from light bulb, but would not hold his weight. Also thought about going in front of traffic. - Says sertraline may have helped in past. - Out of contact with parents since leaving rehab in Derby earlier this year. - Lives in homeless accommodation - reasonably content there.	

CCP-CAC-220506

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
	- Church trying to get him into Haven rehab in Fife - nothing booked yet. - Out of contact w RDS, but interested in restarting methadone, so happy to see them again. - Previous psychiatric admissions to Parkhead, Stobhill & L'dale but not Dykebar. - Two previous prison sentences for armed robbery with a knife. - Due in court November for possession of Heroin & shoplifting - not concerned, except expects to be admonished, has legal representation.	
	IMPRESSION & PLAN - Opiate dependency. - Unclear at this stage whether auditory hallucinations are a secondary phenomenon or stand alone. For further assessment and check old notes. Do not start antipsychotic at this stage. - DHC detox - Refer RDS. - Discharge likely if he is found in possession of drugs, but assess level of psychosis at the time. - Bloods, urine test, physical exam? - Contact father & church worker.	
	f. Bennie	BENNIE Consultant Psychiatrist

CHRONOLOGICAL ACCOUNT OF CARE

PIMS No/CHI No:	0302 823496	WARD:	NORTH
NAME:	Wesley Phillips		
ADDRESS:	14(E) Thrushcraigs		
POST CODE:	PA 2 6PP.		
DOB & GENDER:			

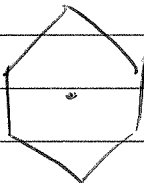
DATE & TIME	THE CHRONOLOGICAL ACCOUNT OF CARE IS A COMPLETE RECORD OF THE PATIENT'S JOURNEY FROM ADMISSION TO DISCHARGE. IT WILL ENCOMPASS ADMISSION STATEMENTS/DETAILS, EVALUATIONS, UPDATES, REVIEWS, MULTIDISCIPLINARY DECISIONS AND RECORDINGS OUT-WITH FORMAL MDT. EACH ENTRY MUST BE TITLED WITH A HEADING 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
29/9/15 Nursing 11:05 pm	Wesley has voiced annoyed voiced he is annoyed at no time out. He has been watching TV with fellow patients	
29.9.15 Nursing 14.00	Nursing. Telephone call to dad, Alexander, he let him know of Wesley's whereabouts following Kardia. Appeared accepting of this information, not significantly concerned however staff are aware that this relationship is quite difficult at the moment.	C. Phillips SN
29/9/15 1600	Telephone call from Jackie Liper of ADS. She'll see Wesley on Thurs 8/10 at 10.00. Please phone her if he is discharged before that. flm	KEWIE Consultant Psychiatrist
29/09/15 Nursing 2100	Nursing. Wesley has settled well into ward. 1/0 of admission late afternoon. Laxapam 2mg administered as per PRN with good effect. Visited by church members in evening.	LIBADY

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
29/9/15 2215	went to do physical examination / bloods but wesley in shower. Before he goes to sleep please can you page #52000 (duty doc) to see him ECG by day team filed @ sinus rhythm.	JWYUE STT.
29/9/15 0050	wesley currently sleeping Please contact duty doc in am to do physical exam / bloods once wesley awakes	JWYUE STT.
30/9/15 (6am)	Nursing. Wesley accepted prescribed 10pm medication with minimal prompting. Minimal interaction only. Widen duty doctor attended. Went to complete physical examination / bloods. Wesley was asleep at this time. Appears to have slept soundly overnight.	JWYUE STT.
30/9/15 0840	Bloods sent - FBC / U&E / LFT / haematocrit / glucose Wesley says had physical yesterday. Cannot see documented but do not want to duplicate Day team to r/v	JWYUE STT.
30/9/15 1115	Nursing - EUTHANIC THROAT CUT THE MORNING. ACCEPTING GUIDANCE FROM STAFF.	Gillie H. AFTER
30/9/15 1530	Nursing - Wesley pacing around ward - requesting to leave hospital - wanting to leave to go kill himself - He was given 1-1 nursing time and agreed to accept plan medication.	P mehmud (Gillie)

CHRONOLOGICAL ACCOUNT OF CARE

PIMS No/CHI No:	0502 823496	WARD:	South
NAME:	Wesley Philips		
ADDRESS:	14(F) Thrush Craigs		
POST CODE:	PA2 6PP		
DOB & GENDER:	050282 (M)		

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
30/9/15 cont'd. -		
15:30	ORAL AS REQUIRED PSYCHOTROPIC MEDICATION MONITORING Date _____ Time given <u>15:30</u> Medication & Dose Given: <u>2g Lorazepam</u> Initiated by: _____ Patient request ☐ Nurse ☐ Medical ☐ Reason for Administration: <u>agitation</u> Restraint occurred?: Yes/<u>No</u> Datix required: Yes ☐ Number _____ Sign <u>[Signature]</u> Print <u>[Signature]</u> Designation <u>(Nurse)</u> Ensure 30-60 minute review is completed and signed on <u>every</u> occasion Patient review 30-60 minutes after administration (tick) Much improved ☒ Slightly improved ☐ No change ☐ Worse ☐ Sign <u>[Signature]</u> Print <u>[Signature]</u> Designation <u>(Nurse)</u> Time <u>18:00</u>	[Signature] [Signature] (Nurse)
30/09/15 16:00	FRZ ADAMS . Physical examination (performed yesterday - documented in retrospect). O/E H&P I + II + O, JVP $\leftrightarrow$ CMT < 2 sec. peripheral oedema Chest clear Good A/E bilaterally.	

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																														
cont'd →	 Abdo soft and non tender. BS ✓ "menstruation". GCS 15/15 AMT 4/4. PERLA. <table><tr><td></td><td>RLU</td><td>LUU</td><td>RLU</td><td>LLU</td></tr><tr><td>Tone</td><td>✓</td><td>✓</td><td>✓</td><td>✓</td></tr><tr><td>Power</td><td>S/S</td><td>S/S</td><td>S/S</td><td>S/S</td></tr><tr><td>Sensation</td><td>✓</td><td>✓</td><td>✓</td><td>✓</td></tr><tr><td>Coordination</td><td>✓</td><td>✓</td><td>✓</td><td>✓</td></tr><tr><td>Reflexes</td><td>✓</td><td>✓</td><td>✓</td><td>✓</td></tr></table> Plan/ Bloods - was unable to obtain adequate samples, will try again/handover to night team. KNOEX written Continue general observations.		RLU	LUU	RLU	LLU	Tone	✓	✓	✓	✓	Power	S/S	S/S	S/S	S/S	Sensation	✓	✓	✓	✓	Coordination	✓	✓	✓	✓	Reflexes	✓	✓	✓	✓	
	RLU	LUU	RLU	LLU																												
Tone	✓	✓	✓	✓																												
Power	S/S	S/S	S/S	S/S																												
Sensation	✓	✓	✓	✓																												
Coordination	✓	✓	✓	✓																												
Reflexes	✓	✓	✓	✓																												
30/a/15	morning - Good benefit from earlier plan, no more voicing intention of leaving. Friend came up with bag of clothing - Friend was overheard saying Wesley has a medical next week. Staff are not convinced by reports of auditory hallucinations - period of assessment to continue.	18:00 P mehod (S/L MOP)																														

CHRONOLOGICAL ACCOUNT OF CARE

PIMS No/CHI No:	1502823496	WARD:	South
NAME:	Wesley Phillips		
ADDRESS:	14F Thrushcraigs Crescent Paisley		
POST CODE:	PA2 6PP		
DOB & GENDER:	15-02-82 (M)		

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
1-10-15 04:25	Nursing: Wesley accepted routine medication, no evidence of distress or agitation. Retired to bed and has slept well overnight.	Joyanas Joyande S/N
1.10.15 11.00	Nursing. Wesley accepted routine medication and breakfast	
	11:15 Morning. Settled and pleasant around 11:30 ward. No concerns.	C Phillips C Phillips
12:30	CHAPLAINCY. CHAPLAIN RESPONDED TO PATIENT'S REQUEST FOR A VISIT. PATIENT DISCLOSED HEARING A VOICE TELLING HIM TO KILL HIMSELF. HE SAID THE VOICE IS GOD ALTHOUGH DOUBTED LOGICALLY HOW THAT CAN BE SO GIVEN HIS KNOWLEDGE THAT GOD IS GOOD. PATIENT APPEARED GENUINELY PUZZLED AND COULD DRAW ON HIS EXPERIENCE OF CHURCH AND QUOTE THE BIBLE. GOD'S ABILITY OR WILL TO FORGIVE HIS SINS IS A KEY ISSUE. CHAPLAIN ACKNOWLEDGED PATIENT'S DISTRESS, NORMALISED HUMAN SIN, AFFIRMED PATIENT'S UNDERSTANDING OF GOD AS GOOD AND GAVE REASSURANCE OF DIVINE FORGIVENESS. WITHIN THE CHRISTIAN NARRATIVE OF SIN IN THE WORLD, PATIENT AND CHAPLAIN EXPLORED THE REALITY OF	

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
	HEALTH RELATED PROBLEMS E.G. PHYSICAL AND MENTAL HEALTH. PATIENT APPEARED SINCERE, GENUINELY ENGAGED AND REFLECTIVE THROUGHOUT THE CHAPLAINCY ENCOUNTER. CHAPLAIN PRAYED AND PROVIDED CHRISTIAN SCRIPTURE UPON REQUEST.	GORDON JONES NHS CHAPLAIN DYKEMAR HOSPITAL <i>Gordon Jones</i>
1.10.15	Nursing. Wesley has been settled around the ward this afternoon, spending time in the lounge area watching TV. Requiring some reassurance with good effect. No concerns to note.	<i>STH</i>
1/10/15	<i>Wesley</i>	
20:40	ORAL AS REQUIRED PSYCHOTROPIC MEDICATION MONITORING Date <i>1/10/15</i> Time given <i>19:00</i> Medication & Dose Given: <i>2mg Lorazepam</i> Initiated by: Patient request ☒ Nurse ☐ Medical ☐ Reason for Administration: <i>agitated state</i> Restraint occurred?: Yes/No Datix required: Yes ☐ Number _____ No ☒ Sign <i>[Signature]</i> Print <i>STH</i> Designation <i>STH</i> Ensure 30-60 minute review is completed and signed on <u>every</u> occasion Patient review 30-60 minutes after administration (tick) Much improved ☒ Slightly improved ☐ No change ☐ Worse ☐ Sign <i>[Signature]</i> Print <i>Mehar</i> Designation <i>STH</i> Time <i>20:40</i>	<i>f mehar</i> <i>[Signature]</i> <i>(STH)</i>
	Wesley complaining of irritability & tension in neck. PRN with good effect.	

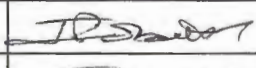
PIMS No/CHI No:	1502823496	WARD:	South
NAME:	Wesley phillips		
ADDRESS:	14F Thrushcraggs Crescent Paisley		
POST CODE:	PA2 6PP		
DOB & GENDER:	15-02-82 ♂		

[illegible]

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
2/16/15	ORAL AS REQUIRED PSYCHOTROPIC MEDICATION MONITORING Date _____ Time given <u>22.30.</u> Medication & Dose Given: <u>2mg lorazepam TABLETS</u> Initiated by: Patient request ☒ Nurse ☐ Medical ☐ Reason for Administration: <u>Voicing suicidal thoughts.</u> Restraint occurred?: Yes/No Datix required: Yes ☐ Number _____ No ☒ Sign <u>[Signature]</u> Print <u>Robertson</u> Designation <u>Nurse</u> Time <u>23.30</u> Ensure 30-60 minute review is completed and signed on <u>every</u> occasion Patient review 30-60 minutes after administration (tick) Much improved ☐ Slightly improved ☒ No change ☐ Worse ☐	<u>[Signature]</u> <u>Robertson</u> nurse
3/18/15	Nursing. Wesley was voicing that "God was telling him to commit suicide, and requested any medication to help stop these voices in his head. 2mg lorazepam given 22.30 with good settling effect soon after. Retired to bed and appears to have slept well overnight with no further issues.	<u>[Signature]</u> <u>Robertson</u> nurse
3/10/15 (1130)	Nursing - Wesley accepted routine medication. Appears relaxed and expressing no concerns this morning. Took advantage of a long lie.	S/N <u>[Signature]</u> Nurse
3/14/15 (1940)	Nursing - EUTHYMIC DURING INTERACTION. SPENDING TIME WATCHING T.V. WITH PEERS. MINIMAL INTERACTION WITH OTHERS.	S/N <u>[Signature]</u> Nurse

CHRONOLOGICAL ACCOUNT OF CARE

PIMS No/CHI No:	15 02823496	WARD:	South
NAME:	Wesley Phillips		
ADDRESS:	14F Thrushorangs Crescent, Paisley		
POST CODE:	PA2 6PP		
DOB & GENDER:	15/2/82 (M)		

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
6-10-15 4/10/15	Nursing: Wesley initially appeared quite settled. Accepting of routine medication and enjoyed some supper prior to returning to bed. Paced the corridor for a short while then went to bed. Appears to have had a comfortable and settled night. No issues raised Nursing	 J. Robertson Nurse
ORAL AS REQUIRED PSYCHOTROPIC MEDICATION MONITORING Date 4/10 Time given 1110. Medication & Dose Given: <u>Lorazepam 2mg</u> Initiated by: <u> </u> Patient request ☐ Nurse ☒ Medical ☐ Reason for Administration: <u>Vocal agitation suicidal ideation</u> Restraint occurred?: Yes/No <u> </u> Datix required: Yes ☐ Number <u> </u> No ☒ Sign <u> </u> Print <u> </u> Designation <u> </u> Ensure 30-60 minute review is completed and signed on <u>every</u> occasion Patient review 30-60 minutes after administration (tick) Much improved ☐ Slightly improved ☒ No change ☐ Worse ☐ Sign <u> </u> Print <u> </u> Designation <u> </u> Time <u>1140pm</u>		

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
4/10/15 1145	Nursing 1-1 intervention Wesley, pleasant in mood this morning However given 1-1 time said he was feeling suicidal. Voices from God had thoughts of throwing himself in front of car. Utilised PBN with slight effect Said he would seek out staff if feelings get too much for him.	 D. McElish
4/10/15 3.55pm	NURSING: - VITAL SIGNS TAKEN TODAY FOR WESLEY AND ARE AS FOLLOWS. B.P $\frac{133}{88}$ Pulse $\frac{75}{103}$ O_2 98%	D. McElish (NIP) D. McElish
4/10/15 18.30	Nurse - Wesley was visited by two friends outwith visiting times - They were off the ward for over 30 minutes - They all returned in a group reporting to staff that Wesley had snuff heroin with him onto the ward - He had been injecting himself in the groin and he has snapped the needle in the site - Nurse has examined site and no way of retrieving the needle - Friends have been	y metant (y metant) (y metant)

CHRONOLOGICAL ACCOUNT OF CARE

PIMS No/CHI No:	1502823496	WARD:	South
NAME:	Wesley Phillips		
ADDRESS:	14F Thrushesway's cresc Paisly		
POST CODE:	PA2 6PP		
DOB & GENDER:	15-02-82 (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
4/6/15 18.30	cont'd. - asked to leave - Nurses are very suspicious that they brought the heroin to the ward - no evidence of this but it seems too much a coincidence - Medical staff should consider discharge due to risks Wesley is taking in our care - Duty Doc contacted & full patch for visit at A+E -	P. McElroy (15/6/15)
04/10/15 19:00	F42 ADAMS - ATSP re: ?needle retained @ groin after IVDU. N/S reported events to me as documented above. Wesley mentioning of any pain / paraesthesia. O/E. Examination patch of skin overlying needle site at @ groin. Firm structure palpable inferior/medial to injection site. @ personal pulse palpable Right lower limb appears normal skin appearance, CRT < 2 secs, well perfused. D/w on-call A+E CONSULTANT - advise non-urgent Xray of area to be performed (provided patient clinically	Abd (N)

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
cont'd →	Amble) and potential for further outpatient follow up with surgeons. NBT for any acute intervention tonight. Plan/ arrange Xray mane 4° physical observations - patient advised to report any new symptoms promptly to N/S. Dfr CONSULTANT PSYCHIATRIST mane	
4/10/15	Nursing - spoke with Wesley to update him on plan.	For review
20:30	documented by medil staff - X-ray known 5/10/15 and surgeons can decide if X-ray if procedure or what procedure needs to take place. Wesley is afraid he will now be discharged from hospital - It was explained that this is highly likely.	pmelhurst (14/10/15)
5-10-15 06:50	Nursing: Wesley returned to bed at onset of shift. Appears to have slept well overnight. No issues noted.	Joynt Joynt 10/15
5/10/15 10:15	Interview in South Ward: Says that he hid Heroin in the grounds "in case I got anxious", and injected it into his groin on Sat 3/5. Needle broke, leaving part in his groin. - I have confirmed to him the surgical and A&E advice is	

CHRONOLOGICAL ACCOUNT OF CARE

PIMS No/CHI No:	1502823496	WARD:	South
NAME:	Wesley Phillips		
ADDRESS:	14 E Thrash Craigs Cres Paisley		
POST CODE:	PA2 6 PP		
DOB & GENDER:	7/2/82 M		

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
	surgical exploration after counter-productive in this scenario, but X-ray appropriate followed by surgical review if indicated. He is willing to get an X-ray, but it will be difficult to contact him after discharge -- no mobile phone, and often changes address.	
	- Discharge today on account of heroin use during detox. No objective evidence of psychosis during admission.	
	- RDS willing to see him as out-patient on Thurs 8/10, but he declines, saying that he is likely to keep using heroin at this point.	
	- Dr Adams will liaise with radiology and with GP.	
	- No psychiatric follow-up.	
	P. J. M. H.	BENJIE Consultant Psychiatrist

NHS GREATER GLASGOW & CLYDE - MENTAL HEALTH SERVICES

[illegible]

PIMS No/CHI No:	050282 3496	WARD:	South
NAME:	Wesley Phelps		
ADDRESS:	14F Throchroigs Crescent, Paisley		
POST CODE:	PA2 6PP		
DOB & GENDER:	050282 (m)		

NEED:
Mental Health, Recovery - discharge.

DATE	INTERVENTION	MINIMUM FREQUENCY OF INTERVENTION	PRINT & SIGN NAME & DESIGNATION
08.9.15	Wesley has been admitted to South ward following self presenting self to F.I.R.S.T. He has been experiencing psychotic symptoms, 'voices' telling him to hang himself. He cannot guarantee his own safety at this time. Wesley has a diagnosis of opiate Dependency - He is known to RDS and currently uses Street Drugs - Heroin &		

[illegible]

DATE:.....

CARE PLAN EVALUTION SHEET

NAME Wesley Phillips CHI NO: 0502823496

PROBLEM NUMBER

Date & Signatures	Evaluation
5/10/15 Ian Sutton	Wesley was admitted in to South Ward on 28/9/15 due to deterioration in mental state associated with psychotic symptoms and suicidal ideation. Wesley also has a diagnosis of opiate dependency. Known to RCGS, had been using street drugs, heroin and unprescribed medication. Wesley has been maintained on a dihydrocodeine reducing regime since admission. Has been using distractionary lorazepam distractionary periodically at times of distress. Within ward Wesley has appeared to self isolate with minimal interaction evident with nursing staff. Continuing to be nursed on general observations, no time out until consultant review. Wesley invited to involve family members in his care if desired. Wesley has been injection heroin on 4/10/15 has needle stick injury in wound site. All relevant medical issues completed. Possible xray to remove needle on 5/10/15. Wesley counselled on this inappropriate action. Sympathy and support as a result. For review with Dr. Rennie on mon 5/10/15. Wesley unable to sign care plan as he is asleep when completed review again 1/52

PIMS No/CHI No:	050282 3496	WARD:	South
NAME:	Wesley Philips		
ADDRESS:	11F Thrusdells, Crescent. Paisley		
POST CODE:	PA2 6PP		
DOB & GENDER:	050282 (m.)		

2

Therapeutic Intervention.

DATE	INTERVENTION	MINIMUM FREQUENCY OF INTERVENTION	PRINT & SIGN NAME & DESIGNATION
28.9.15	Wesley has been admitted to South ward this afternoon. He has agreed to come into hospital for treatment for psychotic symptoms, at time of admission Wesley requires to be nursed in a place of safety. He will be given opportunity to engage in therapeutic activities which will benefit him on his recovery journey. He will be given opportunity to speak with staff on 1-1		

[illegible]

DATE:.....

CARE PLAN EVALUTION SHEET

NAME: Wesley Phillips CHI NO: 050282 3496

PROBLEM NUMBER C2

Date & Signatures	Evaluation
5/10/15 15/05/15	Wesley continues to be offered opportunity to engage in services available within ward. to develop confidence and self esteem. Nursing staff will attempt to develop a therapeutic relationship based on empathy, trust and confidentiality. Wesley appears to be unable to participate in therapies available at this time. continues to be allowed involvement as Wesley is able to engage. Staff have advised Wesley to utilize nursing staff at times of distress for offer reassurance. Referred 152. (S)

Uswg

CARE PLAN

PIMS No/CHI No:	050282 3496	WARD:	South
NAME:	Wesley Philips		
ADDRESS:	111F Thrashcraigs Crescent		
POST CODE:	PA2 6PP		
DOB & GENDER:	050282 (m)		

NEED No.

3

NEED:

Legal Aspects of Care.

DATE	INTERVENTION	MINIMUM FREQUENCY OF INTERVENTION	PRINT & SIGN NAME & DESIGNATION
28.9.15	Wesley has agreed to come into hospital to receive care & treatment for psychotic symptoms. He is an informal Patient and will be nursed on General observations. If there becomes a concern for his safety or safety of others then his legal status will be reviewed.		KL Martin K Martin

DATE	INTERVENTION	MINIMUM FREQUENCY OF INTERVENTION	PRINT & SIGN NAME & DESIGNATION

PATIENT/CARER'S VIEW/UNDERSTANDING OF INTERVENTIONS

STAFF SIGNATURE:

M. Cuthbert.....

DATE: 22.9.15

PATIENT / CARER SIGNATURE:.....

DATE:.....

CARE PLAN EVALUATION SHEET

NAME Wesley Phillips CHI NO: 0502823496

PROBLEM NUMBER[illegible]

CARE PLAN

PIMS No/CHI No:	050288 3496	WARD:	South
NAME:	Wesley Phillips		
ADDRESS:	14F Thrushcraigs Crescent, Paisley.		
POST CODE:	PA2 6PP		
DOB & GENDER:	05 02 88 (m)		

NEED NO.

4

NEED:

Physical Aspect of care.

DATE	INTERVENTION	MINIMUM FREQUENCY OF INTERVENTION	PRINT & SIGN NAME & DESIGNATION
	Wesley will be given a		
	Full Physical examination,		
	which will include, Bloods &		
	ECG as per hospital Protocol.		
	and if any abnormalities		
	are detected appropriate		
	intervention will follow.		
	Wesley has been diagnosed		
	with Tourette's disorder		
	and with emotionally unstable		
	personality. He claims to		
	smoke 10 cigarettes daily.		
	Physical health will be		
	monitored with weights		
	& vital signs checked weekly		

[illegible]

Shlantz

DATE: 22.9.15

PATIENT/CARER SIGNATURE:.....

DATE:.....

CARE PLAN EVALUATION SHEET

NAME: Wesley Phillips CHI NO: 0502823496

PROBLEM NUMBER.[illegible]

SEM-3m

NHS GREATER GLASGOW & CLYDE - MENTAL HEALTH CARE PLAN
MULTIDISCIPLINARY TEAM MEETING RECORD



NAME:	Wesley Phillips	GH No:	
NAMED NURSE:			

CURRENT DETENTION STATUS:	
CURRENT SAFE AND SUPPORTIVE OBSERVATION LEVEL:	
CURRENT TIME OUT:	
SUSPENSION EXPIRY DATE:	

RELEVANT INFORMATION SINCE LAST REVIEW: COMMENT ON ANY DETERIORATION OR IMPROVEMENT ON MENTAL AND PHYSICAL STATE, SLEEP, APPETITE, AGGRESSION, HOUSING ISSUES/DEVELOPMENTS, INVOLVEMENT IN THERAPIES AND ACTIVITIES ETC

Admission 28.9.15 - God telling him to
 hang himself.
 opiate dependency
 EUPD

CARER/RELATIVES/NAMED PERSON VIEWS: COMMENT ON ANY CONCERNS VOICED BY CARERS OR RELATIVES REGARDING CARE AND TREATMENT SINCE THE LAST REVIEW

INFORMATION COMPLETED BY:

Print Name _____ Signed: _____ Date: _____

IN ATTENDANCE AT MDT

Dr Bennie Andy Fischer
 Sezie Burke Camille Phelps

Referrals to be made following meeting:			
CMHT		Child Protection	
IHTT		Adult Support and Protection	
Social Work/MHO		Dietitian	
Housing		Speech and Language Therapy	
Psychological Therapies		Tissue Viability	
Other....		Other....	

SUMMARY OF DECISIONS TAKEN / ACTION REQUIRED: (PLEASE INCLUDE THE RATIONALE BEHIND ANY DECISION TAKEN)

wasley voicing suicidal thoughts, drawing himself, hanging himself, putting himself in front of car. States still have thoughts but wants to get better.

MEDICATION REVIEW AND CHANGES:

Dihydrocodone reducing regime

REVIEW AND UPDATE OF THE CLINICAL RISK SCREENING AND MANAGEMENT TOOL: (TO BE RECORDED IN MANAGEMENT PLAN)

No new risk identified.
Suicidal thoughts but no plans or intent.

PHYSICAL HEALTHCARE INVESTIGATIONS AND REQUIREMENTS:

Physical still to be carried out.
CDS, bloods.

If required is the patient suitable for early discharge with support from IHTT or CMHT?

Yes ☐

No ☒

UPDATED DETENTION STATUS FOLLOWING:

MDT: N/A

UPDATED TIME OUT FOLLOWING MDT:

Nil time out whilst detained

UPDATED SUSPENSION FORM:

N/A

CURRENT SAFE AND SUPPORTIVE OBSERVATION LEVEL:

FORWARD PLAN THAT INDICATES WHEN AN ENHANCED OBSERVATION LEVEL CAN BE LOWERED (PLEASE DETAIL - TO BE COMPLETED BY RMO)

General.

MEETING OUTCOMES DISCUSSED WITH: (PLEASE TICK)

ENT ☐ NAMED PERSON ☐ CARER ☐ ADVOCATE ☐ OTHER (PLEASE SPECIFY)

LET BY:

NAME: C. J. J. J.

SIGNED: 

DATE 29.9.15

T SIGNATURE:

DATE

APPENDIX 2

Suggested emergency management of withdrawal symptoms, as per the Subjective Opioid Withdrawal Scale (SOWS) (Appendix 4) for those patients:

- Awaiting further assessment
- Awaiting confirmation of patients Methadone/ Buprenorphine dose
- Short term admissions for whom no through care is possible

Dihydrocodeine to be prescribed in doses of up to 60mgs four times daily. This dose can be reduced or maintained during short admissions depending on the clinical condition of the patient. **Do not supply on discharge and do not prescribe to pregnant women**

If required, incremental reductions can be daily or every other day.

Note: Although this is established practice supported by some evidence base, this is an unlicensed use of dihydrocodeine. Liquid preparations are the preferred formulation to enable supervised administration.

APPENDIX 4

Assessment of Opiate Withdrawal – Subjective Opioid Withdrawal Scale (SOWS)

Observe the patient and score accordingly. A score of more than 5 is strongly suggestive of opiate withdrawal in a dependent patient.

	2	1	0
Pupil size	Wide	Normal	Pin point
Palms	Wet	Moist	Dry
Skin	Goosebumps	Cold	Warm
Nasal	Running	Sniffing	Dry
Agitation	Can't sit	Agitated	Calm
GIT	Vomiting	Nausea	Normal
Pulse	>100	80-100	<80
TOTAL			

Nutrition Profile

Name: <u>Wesley Phillips</u>	Date of admission: <u>28/9/15</u>
Address: <u>14F Thrusdycraig Crescent</u>	Time: <u>15.00</u>
DoB: <u>5.2.88</u>	HOSPITAL: <u>Dykebar</u>
CHI number: <u>3496</u>	Ward: <u>South</u>
Affix patient data label	

To be recorded within 24 hours of admission*		
Height: <u>1.84</u> metres	Actual ☐ Patient/ carer reported ☐ Alternative measurement ☐	
Weight: <u>126.7</u> kg	Actual ☐ Patient/ carer reported ☐ Alternative measurement ☐	
Recent unplanned weight loss: Yes ☐ No ☐		
If 'Yes' how much?: <u>kg</u> Over what period of time?: <u>weeks/months</u>		
Is there evidence of recent weight loss?		
No ☐ Loose clothing ☐ History of reduced food intake/appetite ☐ Swallowing problem ☐		
Dietary requirements (e.g. vegetarian; texture modified diet and fluids; halal; kosher)		Yes ☐ No ☐
Please state:		
Food Allergies: Yes ☐ No ☐ If 'Yes' please state:		
Eating likes and dislikes (including appetite):	Drinking likes and dislikes:	Patient NBM Yes ☐ No ☐ If 'Yes' why?:
Are there any contributing factors that may affect food intake such as physical (e.g. swallowing difficulties, loose teeth), physiological (e.g. nausea), psychological (e.g. dementia), social or environmental ? Yes ☐ No ☐		
Please specify all factors:		
Is the patient on oral nutritional supplements? Yes ☐ No ☐		
If 'Yes' please state:		
Is the patient experiencing oropharyngeal swallowing problems (excluding oesophageal issues e.g. GORD, Stricture)? Yes ☐ No ☐		
If 'Yes' please complete Screening Tool for Oropharyngeal Swallow Symptoms (STOPSS). If oesophageal problem present please discuss with medical staff.		
Is there a need for equipment and/or assistance with eating and drinking?		Yes ☐ No ☐
If 'Yes' please state:		
Has this patient received written information about inpatient food (e.g. "Food in Hospitals" leaflet)?		
Yes ☐ No ☐ Not applicable (received on previous admission) ☐		
Profile completed by: Name (PRINT):	Signature:	Date:

NOTE: This is ADMISSION DATA - please refer to changes in Care Plan.

* Quality Improvement Scotland (2003). Food, Fluids and Nutritional Care in Hospitals Edinburgh QIS

If 'Yes' please follow LCP advice as screening for malnutrition may not be appropriate.

[illegible][illegible]

Score of Overall Risk of Malnutrition	Action Required
0	LOW RISK – <i>Routine Clinical Care</i> Repeat screening. Hospital AcuteWeekly Hospital RehabilitationMonthly
1	MEDIUM RISK – <i>Observe</i> - Document dietary intake for 3 days on a Food Record Chart. - Encourage oral intake. - Assist patient to choose high-energy meals/snacks and offer full cream milk to drink with and between meals. - Repeat screening weekly.
2 or more	HIGH RISK – <i>Treat*</i> - Refer to Dietitian and document food intake for 3 days on a Food Record Chart. - Encourage oral intake. - Assist patient to choose high-energy meals/snacks and offer full cream milk to drink with and between meals. - Monitor and review Care Plan weekly. * Unless detrimental or no benefit is expected from nutritional support e.g. imminent death.

Management Plan

FOR ALL PATIENTS

- Provide help and advice on food choices and eating and drinking when necessary.
- Treat underlying conditions and initiate appropriate treatment to relieve symptoms that affect nutritional intake e.g. nausea, vomiting, constipation, diarrhoea and/or pain.
- Refer to dietitian if any specialist advice is required.
- Use a recognised system to identify when equipment or assistance is required at mealtimes (e.g. red mats, coloured napkins).
- REMEMBER TO CONSIDER YOUR PATIENT'S HYDRATION REQUIREMENTS.
- Ensure Discharge Plan includes most recent 'MUST' Score and any necessary follow-up requirements.

Referral Services		Referred by	Method of referral	Reason for referral
Nutritional Support Team	Date Referred / /			
Dietitian	Date Referred: / /			
Speech and Language Therapy	Date Referred: / /			
Occupational Therapy	Date Referred / /			
Dental Service	Date Referred / /			

Multidisciplinary Nutrition Care Plan

[illegible]

Step 2 - Weight Loss Score

Weight before weight loss (kg)	Score 0 Wt loss <5%	Score 1 Wt loss 5-10%	Score 2 Wt loss >10%
--------------------------------	------------------------	--------------------------	-------------------------

Weight before weight loss (st/lb)	Score 0 Wt loss <5%
--------------------------------------	------------------------

Height (feet and inches)

[illegible]

Weight (stones and pounds)

Weight before weight loss (kg)	Score 0 Wt loss <5%	Score 1 Wt loss 5-10%	Score 2 Wt loss >10%
34 kg	<1.7 kg	1.7-3.4 kg	>3.4 kg
36 kg	<1.8 kg	1.8-3.6 kg	>3.6 kg
38 kg	<1.9 kg	1.9-3.8 kg	>3.8 kg
40 kg	<2 kg	2-4 kg	>4 kg
42 kg	<2.1 kg	2.1-4.2 kg	>4.2 kg
44 kg	<2.2 kg	2.2-4.4 kg	>4.4 kg
46 kg	<2.3 kg	2.3-4.6 kg	>4.6 kg
48 kg	<2.4 kg	2.4-4.8 kg	>4.8 kg
50 kg	<2.5 kg	2.5-5 kg	>5 kg
52 kg	<2.6 kg	2.6-5.2 kg	>5.2 kg
54 kg	<2.7 kg	2.7-5.4 kg	>5.4 kg
56 kg	<2.8 kg	2.8-5.6 kg	>5.6 kg
58 kg	<2.9 kg	2.9-5.8 kg	>5.8 kg
60 kg	<3 kg	3-6 kg	>6 kg
62 kg	<3.1 kg	3.1-6.2 kg	>6.2 kg
64 kg	<3.2 kg	3.2-6.4 kg	>6.4 kg
66 kg	<3.3 kg	3.3-6.6 kg	>6.6 kg
68 kg	<3.4 kg	3.4-6.8 kg	>6.8 kg
70 kg	<3.5 kg	3.5-7 kg	>7 kg
72 kg	<3.6 kg	3.6-7.2 kg	>7.2 kg
74 kg	<3.7 kg	3.7-7.4 kg	>7.4 kg
76 kg	<3.8 kg	3.8-7.6 kg	>7.6 kg
78 kg	<3.9 kg	3.9-7.8 kg	>7.8 kg
80 kg	<4 kg	4-8 kg	>8 kg
82 kg	<4.1 kg	4.1-8.2 kg	>8.2 kg
84 kg	<4.2 kg	4.2-8.4 kg	>8.4 kg
86 kg	<4.3 kg	4.3-8.6 kg	>8.6 kg
88 kg	<4.4 kg	4.4-8.8 kg	>8.8 kg
90 kg	<4.5 kg	4.5-9 kg	>9 kg
92 kg	<4.6 kg	4.6-9.2 kg	>9.2 kg
94 kg	<4.7 kg	4.7-9.4 kg	>9.4 kg
96 kg	<4.8 kg	4.8-9.6 kg	>9.6 kg
98 kg	<4.9 kg	4.9-9.8 kg	>9.8 kg
100 kg	<5 kg	5-10 kg	>10 kg
102 kg	<5.1 kg	5.1-10.2 kg	>10.2 kg
104 kg	<5.2 kg	5.2-10.4 kg	>10.4 kg
106 kg	<5.3 kg	5.3-10.6 kg	>10.6 kg
108 kg	<5.4 kg	5.4-10.8 kg	>10.8 kg
110 kg	<5.5 kg	5.5-11 kg	>11 kg
112 kg	<5.6 kg	5.6-11.2 kg	>11.2 kg
114 kg	<5.7 kg	5.7-11.4 kg	>11.4 kg
116 kg	<5.8 kg	5.8-11.6 kg	>11.6 kg
118 kg	<5.9 kg	5.9-11.8 kg	>11.8 kg
120 kg	<6 kg	6-12 kg	>12 kg
122 kg	<6.1 kg	6.1-12.2 kg	>12.2 kg
124 kg	<6.2 kg	6.2-12.4 kg	>12.4 kg
126 kg	<6.3 kg	6.3-12.6 kg	>12.6 kg

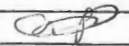
Weight before weight loss (st/lb)	Score 0 Wt loss <-5%
5st 4lb	<4lb
5st 7lb	<4lb
5st 11lb	<4lb
6st	<4lb
6st 4lb	<4lb
6st 7lb	<5lb
6st 11lb	<5lb
7st	<5lb
7st 4lb	<5lb
7st 7lb	<5lb
7st 11lb	<5lb
8st	<6lb
8st 4lb	<6lb
8st 7lb	<6lb
8st 11lb	<6lb
9st	<6lb
9st 4lb	<7lb
9st 7lb	<7lb
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13st 11lb	<10lb
14st	<10lb
14st 4lb	<10lb
14st 7lb	<10lb
14st 11lb	<10lb
15st	<11lb
15st 4lb	<11lb
15st 7lb	<11lb
15st 11lb	<11lb
16st	<11lb
16st 4lb	<11lb
16st 7lb	<12lb
16st 11lb	<12lb

CLINICAL INVESTIGATIONS SHEET

PIMS No/CHI No:	05 02823496	WARD:	Socly
NAME:	Wesley Phillips		
ADDRESS:	14F Throedger's Crescent		
POST CODE:	DA2 6PP		
DOB & GENDER:	5.2.82 (M)		

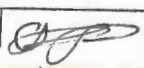
TEST / INVESTIGATION DESCRIPTION	DATE REQUEST / COLLECTED	NOTE OF RESULTS	SIGNATURE
----------------------------------	--------------------------	-----------------	-----------

**DYKEBAR ACUTE ADMISSION UNIT
MULTISTIX URINALYSIS RESULTS**

Patient's Name	Wesley	DoB	
DATE	29.9.15	TIME (24HR)	
Glucose	Neg	Blood	Neg
Bilirubin	Neg	Ph	6.5
Ketones	Neg	Protein	Neg
Sp. Gravity	1.030	Urobilinogen	Normal
Any Other Observations			
Staff Signature: 			

AFFIX THESE RESULTS TO THE INVESTIGATIONS SHEET

DYKEBAR ACUTE ADMISSION UNIT - DRUG SCREEN

Patient's Name	Wesley	Diagnosis	
Date	29.9.15	Time	
Test Performed	Tick	+ve	-ve
Amphetamine AMP	✓	X	✓
Benzodiazepines BZO	✓	✓	
Cannabis THC	✓		✓
Ecstasy M-AMP	✓		✓
Methadone MTD	✓	✓	
Opiates MOR	✓	✓	
Cocaine	✓		✓
TEST REFUSED			
Name & Signature of Tester: 			

29-Sep-2015 15:13:52

Vent. rate 69 bpm
PR interval 156 ms
QRS duration 90 ms
QT/QTc 422/452 ms
P-R-T axes 50 77 53

Normal sinus rhythm
Normal ECG

Wendy PHILLIPS
1502823496

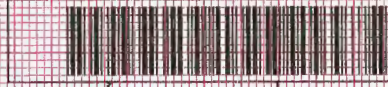
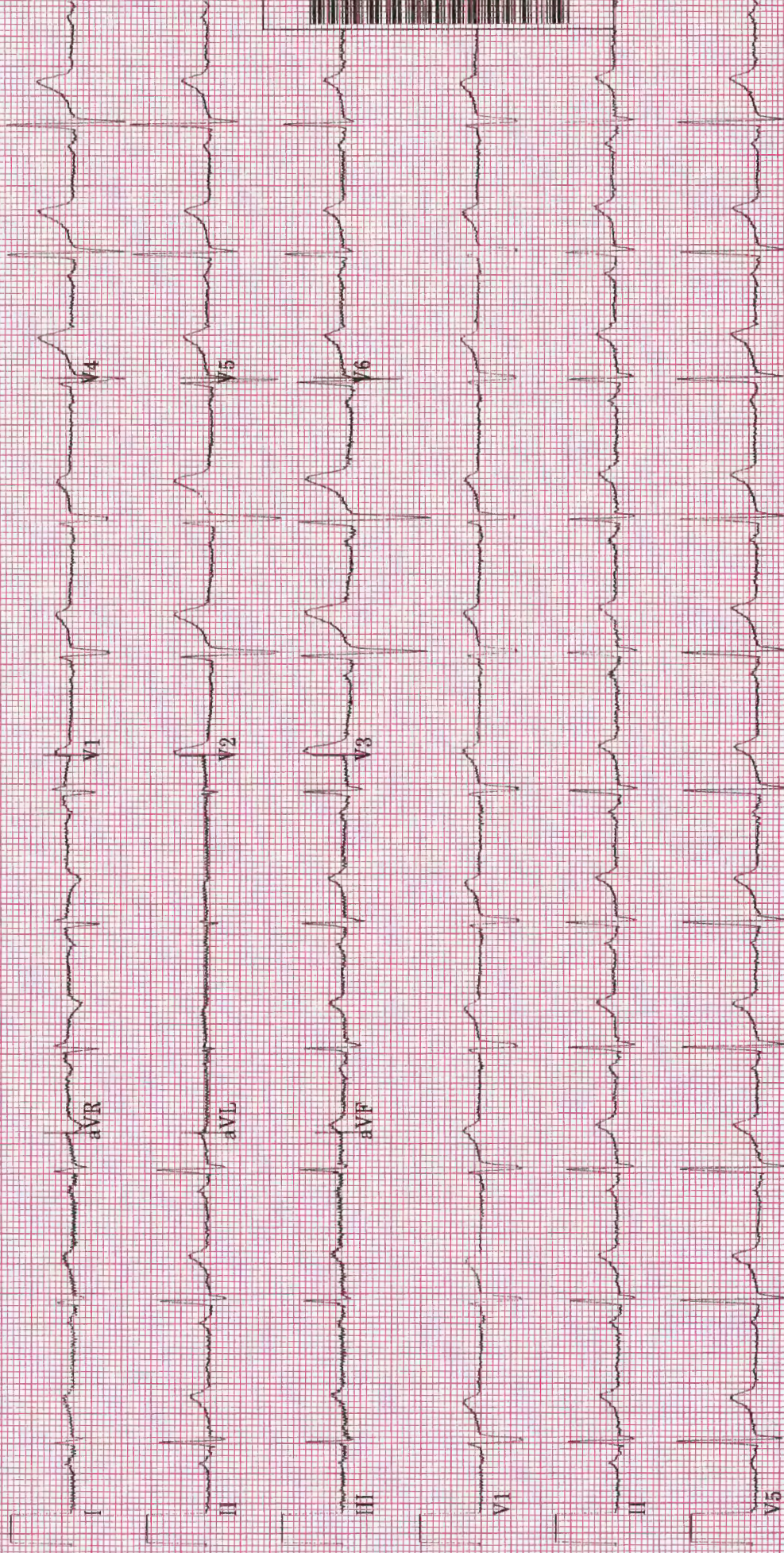
For review.

Technician:
Test ind.

Visit:

Referred by:

Unconfirmed



Heart rate 76 bpm
PR interval 162 ms
QRS duration 100 ms
QT/QTc 396/445 ms
P-R-T axes 38 12 45

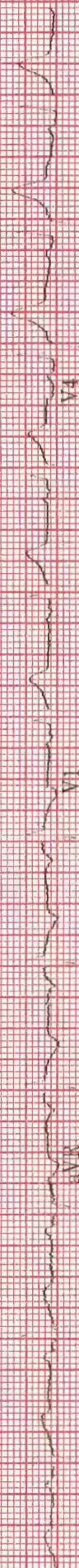
Acc 901

Technician

COMMENTS

Referred by:

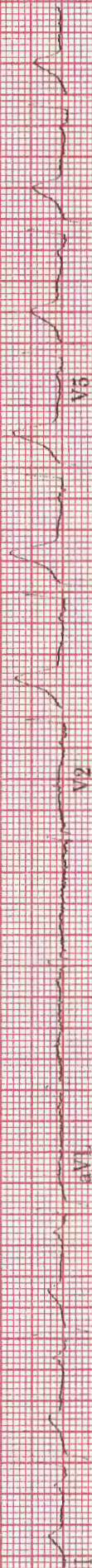
Unconfirmed



aVR

V1

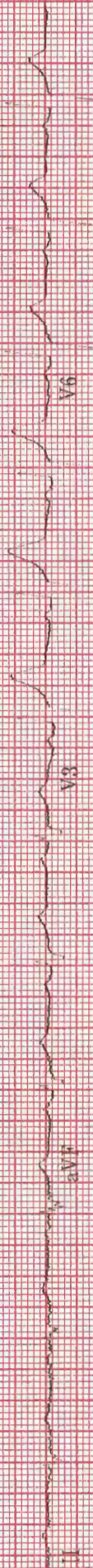
V4



aVL

V2

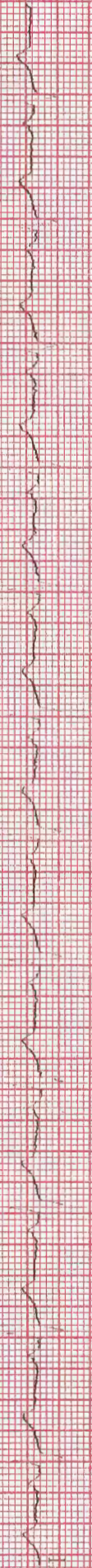
V5



aVF

V3

V6

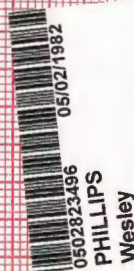


100 Hz 25.0 mm/s 10.0 mm/mV

4 by 2.5s - 1 rhythm 1d

MAC55 009A

12SL™ V237



5-Feb-1982

Male Caucasian

Room: RDS

Loc: 876 Opt: 75

Vent. rate 101 bpm

PR interval 158 ms

QRS duration 84 ms

QT/QTc 394/510 ms

P-R-T axes 34 42 47

*** Poor data quality, interpretation may be adversely affected

Sinus tachycardia

Junctional ST depression, probably normal

LONT DT

di

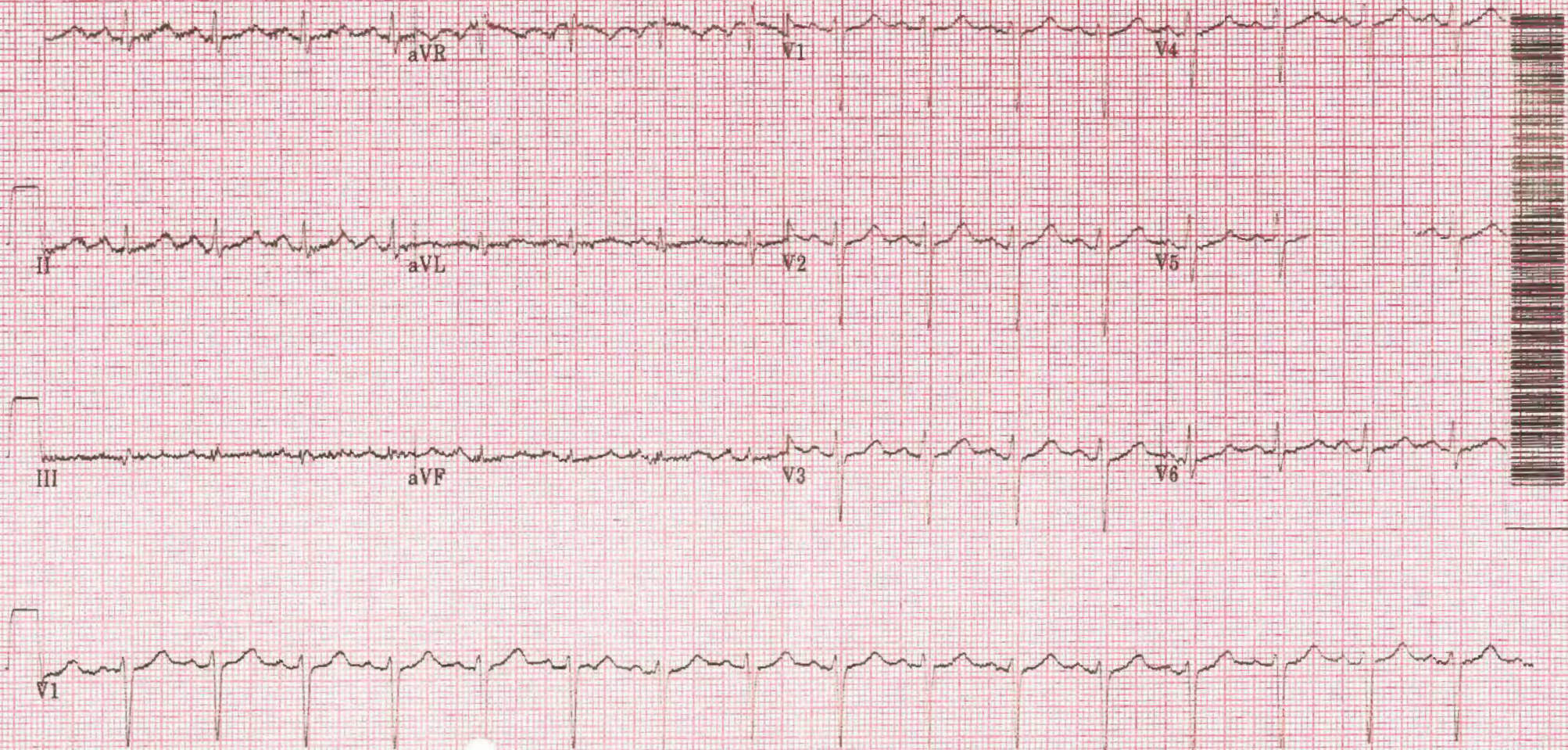
fu
C.

Technician: 875

Test ind:

Referred by: MCMAHON, DR

Unconfirmed



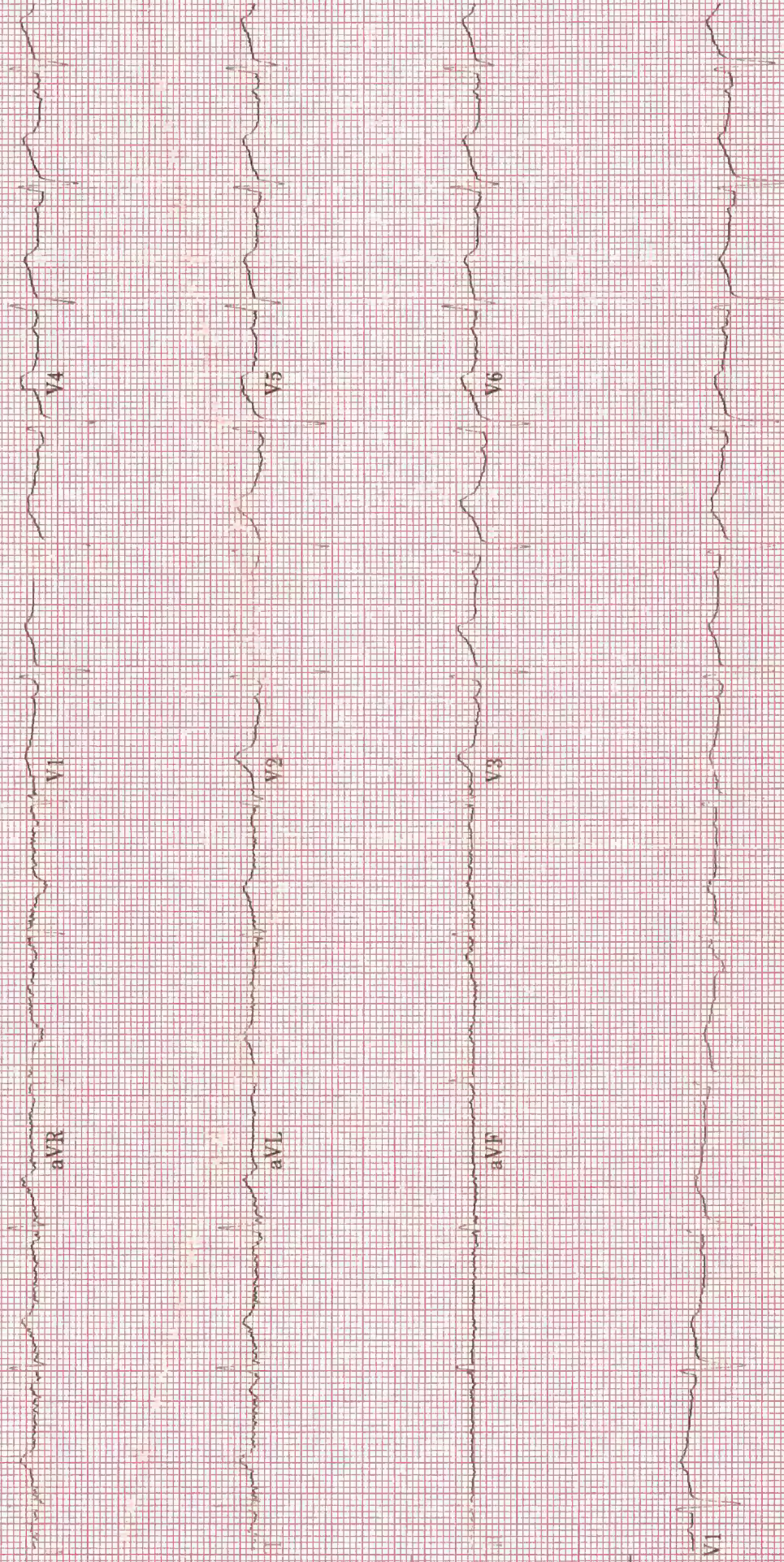
5-Feb-1982 Vent. rate 71 bpm
 Male Caucasian PR interval 136 ms
 Zoom: RDS QRS duration 90 ms
 102 QT/QTc 44/52 ms
 Opt. 14 P-R-T axes 45 11 24

Technician: 14
 Test no:

Referred by: MCMAHON

Unconformed

Allyouan



PHILLIPS, WESLEY

ID:0502823496

28-AUG-2012 14:51:36

Royal Alexandra Hospital-GPOP ROUTINE RETRIEVAL

05-FEB-1982 (30 yr)
Male Caucasian

Room:GPOP
Loc:83 Option:29

Vent. rate 98 BPM
PR interval 154 ms
QRS duration 90 ms
QT/QTc 384/490 ms
P-R-T axes 25 69 22

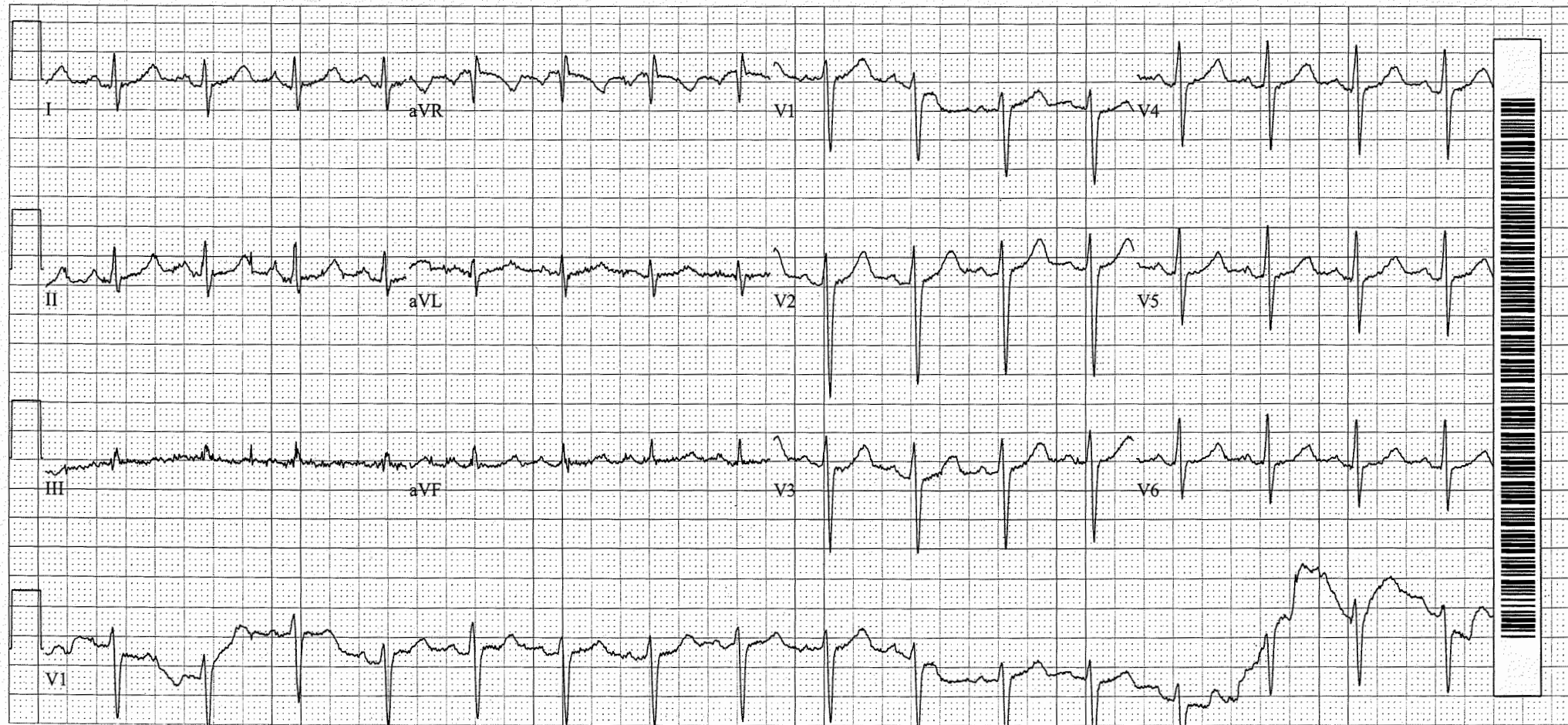
*** Poor data quality, interpretation may be adversely affected
Normal sinus rhythm
Prolonged QT
When compared with ECG of 08-MAY-2012 11:45,
Vent. rate has increased BY 47 BPM
QT has lengthened

Technician:GLEN CUNNINGHAM
Test ind:

Monitor
feline ppts

Referred by:

Confirmed By: GARY IRVINE



25mm/s 10mm/mV 150Hz MUSE 7.0.0 12SL 239 CID: 1

EID:38 EDT: 13:40 07-SEP-2012 ORDER:

5-Feb-1982

Male Caucasian

Room: GPOP

Loc: 83 Opt: 29

Vent. rate 98 bpm

PR interval 154 ms

QRS duration 90 ms

QT/QTc 384/490 ms

P-R-T axes 25 69 22

Poor data quality, interpretation may be affected
Normal sinus rhythm
Prolonged QT

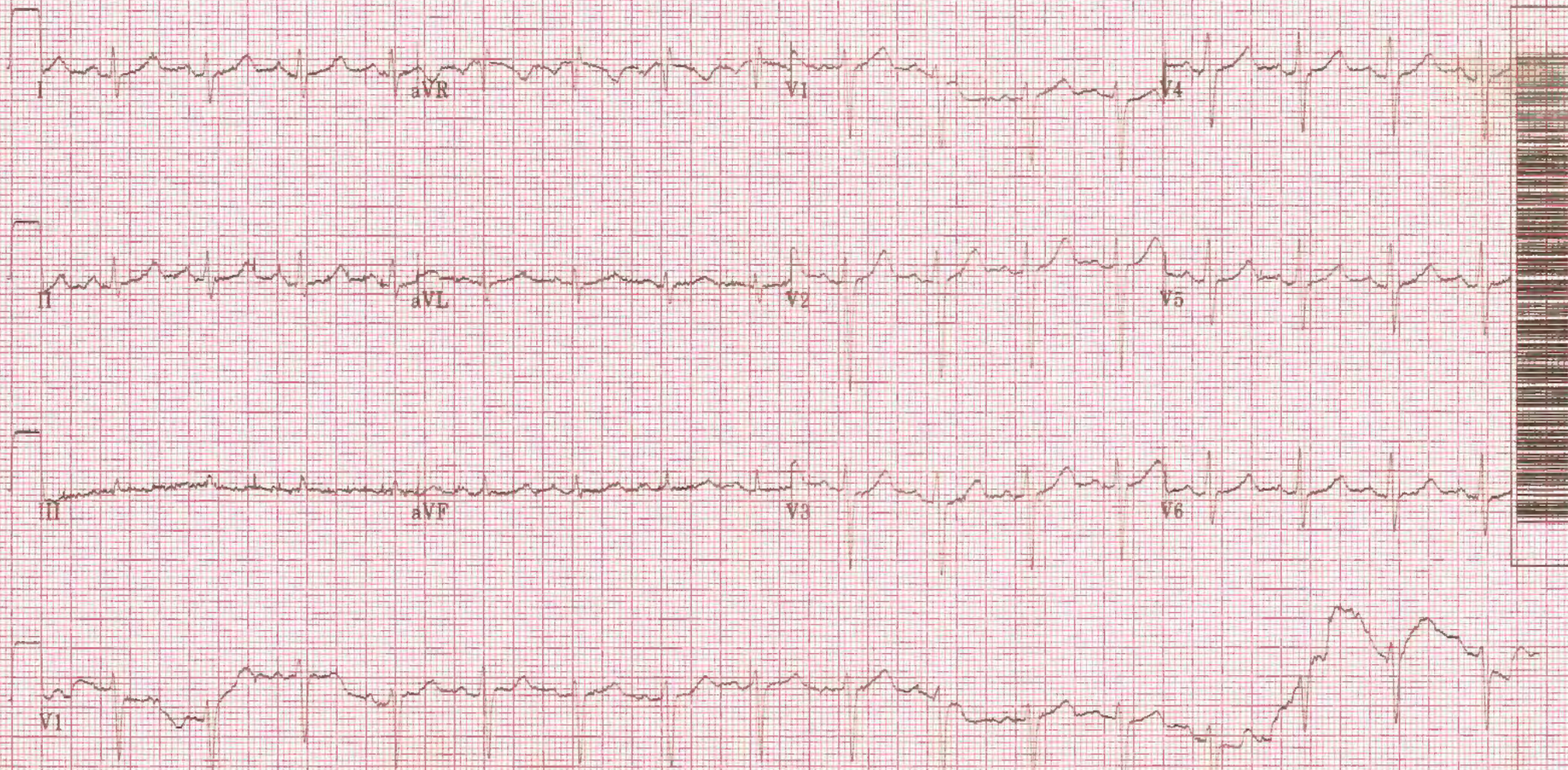
Technician: 29

Test ind:

Referred by:

Unconfirmed

N Carey



CLYDE HOSPITALS HAEMATOLOGY REPORT

Surname: PHILLIPS	Location: Renfrewshire Drug Service
Forename: WESLEY	20 Back Sneddon Street
DOB/Age: 05.02.82 Sex: Male	Paisley
CHI/Unit No: 0502823496	Greater Glasgow & Clyde
Address: 14F THRUSHCRAIGS CRESCENT	Requestor: Elaine McLellan
Details: HEP C ASSESSMENT	Ext Labno:

Lab No: B,16.7081721
 Collected: 26.01.16 14:00
 Authorised: 27.01.16

Received: 26.01.16 17:07
 Authoriser:

FER

Serum Ferritin 93 ug/l (20-300)

CLYDE HOSPITALS HAEMATOLOGY REPORT

[Form:RAH]

Surname: PHILLIPS	Location: Renfrewshire Drug Service
Forename: WESLEY	20 Back Sneddon Street
DOB/Age: 05.02.82 Sex: Male	Paisley
CHI/Unit No: 0502823496	Greater Glasgow & Clyde
Address: 14F THRUSHCRAIGS CRESCENT	Requestor: Elaine McLellan
Details: HEP C ASSESSMENT	Ext Labno:

[[CURRENT]]

Lab Number	B,16.7081723.A	B,15.8351136.W	B,15.8015701.T
Date/Time collected	26.01.16 14:00	30.09.15 08:30	11.02.15 09:07
Date/Time received	26.01.16 17:07	30.09.15 20:30	11.02.15 11:12

WBC	x10 ⁹ /l (4.0-11.0)	6.3	7.7	7.7
RBC	x10 ¹² /l (4.50-6.50)	5.10	5.14	4.93
Haemoglobin	g/l (130-180)	140	142	136
Haematocrit	l/l (0.400-0.540)	0.443	0.453	0.426
MCV	fl (80.0-100.0)	86.9	88.1	86.4
MCH	pg (27.0-32.0)	27.5	27.6	27.6
Platelet Count	x10 ⁹ /l (150-400)	269	388	309
Neutrophils	x10 ⁹ /l (2.0-7.5)	3.8	3.0	4.1
Lymphocytes	x10 ⁹ /l (1.5-4.0)	1.9	3.5	2.7
Monocytes	x10 ⁹ /l (0.2-0.8)	0.5	0.5	0.6
Eosinophils	x10 ⁹ /l (0.0-0.4)	0.1	0.6	0.3
Basophils	x10 ⁹ /l (0.0-0.1)	0.0	0.1	0.0
Nucleated RBC	x10 ⁹ /L	0.0	0.0	0.0
Myelocytes	x10 ⁹ /L			
Blasts	x10 ⁹ /L			
Others	x10 ⁹ /L			

CLYDE HOSPITALS HAEMATOLOGY REPORT

Surname: **PHILLIPS** Location: **South Ward**
 Forename: **WESLEY** **Dykebar Hospital**
 DOB/Age: **05.02.82** Sex: **Male** **Grahamston Rd Paisley**
 CHI/Unit No: **0502823496** **Greater Glasgow & Clyde**
 Address: **0/1 51 THRUSHCRAIG CRES** Requestor: **Dr Alan Bennie**
 Details: **opiate dependent auditory hallucinations** Ext Labno:

[[CURRENT]]

Lab Number	B,15.8351136.W	B,15.8015701.T	B,15.8004265.G
Date/Time collected	30.09.15 08:30	11.02.15 09:07	10.02.15 09:33
Date/Time received	30.09.15 20:30	11.02.15 11:12	10.02.15 11:12

WBC	x10 ⁹ /l (4.0-11.0)	7.7	7.7	8.6
RBC	x10 ¹² /l (4.50-6.50)	5.14	4.93	5.22
Haemoglobin	g/l (130-180)	142	136	142
Haematocrit	l/l (0.400-0.540)	0.453	0.426	0.482
MCV	f1 (80.0-100.0)	88.1	86.4	92.3
MCH	pg (27.0-32.0)	27.6	27.6	27.2
Platelet Count	x10 ⁹ /l (150-400)	388	309	287
Neutrophils	x10 ⁹ /l (2.0-7.5)	3.0	4.1	5.8
Lymphocytes	x10 ⁹ /l (1.5-4.0)	3.5	2.7	2.0
Monocytes	x10 ⁹ /l (0.2-0.8)	0.5	0.6	0.6
Eosinophils	x10 ⁹ /l (0.0-0.4)	+ 0.6	0.3	0.2
Basophils	x10 ⁹ /l (0.0-0.1)	0.1	0.0	0.0
Nucleated RBC	x10 ⁹ /L	0.0	0.0	0.0
Myelocytes	x10 ⁹ /L			
Blasts	x10 ⁹ /L			
Others	x10 ⁹ /L			
ESR	mm/hr (1-10)			

[RAH Run: 990]

CLYDE HOSPITALS HAEMATOLOGY REPORT

Surname: **PHILLIPS** Location: **Renfrewshire Drug Service**
 Forename: **WESLEY** **20 Back Sneddon Street**
 DOB/Age: **05.02.82** Sex: **Male** **Paisley**
 CHI/Unit No: **0502823496** **Greater Glasgow & Clyde**
 Address: **14F THRUSHCRAIGS CRESCENT** Requestor: **Elaine McLellan**
 Details: **HEP C ASSESSMENT** Ext Labno:

Lab No: **B,16.7081724**
 Collected: **26.01.16 14:00**
 Authorised: **26.01.16**

Received: **26.01.16 17:07**
 Authoriser:

CS

Prothrombin Time	10	S	(9-13)
PT Ratio	0.9		
APTT	29	S	(27-38)
APTT Ratio	1.0		(0.8-1.2)
Thrombin time	12	S	(11-15)
TCT ratio	1.0		

Number	0502823496	Address	PAISLEY	Renfrewshire Drug Service
CRN	DYK050282349 IRH195834		PA6 2PP	Renfrewshire Drug Service
Surname	PHILLIPS	Sex	Male	10 St. James Street
Forename	WESLEY	Date of Birth	05/02/1982	Paisley
				, PA3 2HT
Clinical Details	loss	Laboratory Ref.	BL253633A	Page 1 of 1

PT	10.4	seconds	(9.0 - 13.0)
APTT	34.9	seconds	(27.0 - 38.0)
Thrombin Time	12.8	seconds	(11.0 - 15.0)

HAEMATOLOGY

(Signature)

Date / Time Received 06/09/2013 11:43
Date / Time Reported 06/09/2013 12:51

HAEMATOLOGY

Coagulation Screen

Date / Time Collected
06/09/2013 10:15

[RAH Run: 706

C L Y D E H O S P I T A L S
H A E M A T O L O G Y R E P O R T

Surname:	PHILLIPS	Location:	South Ward
Forename:	WESLEY		Dykebar Hospital
DOB/Age:	05.02.82		Grahamston Rd Paisley
CHI/Unit No:	0502823496		Greater Glasgow & Clyde
Address:	0/1 51 THRUSHCRAIG CRES	Requestor:	BENNIE
Details:	OPIATE DEPENDANT	Ext Labno:	

Lab No: **B,15.7419951**
Collected: **30.09.15 08:30**
Authorised: **01.10.15**

Received: **30.09.15 20:29**
Authoriser:

B12

Serum Vitamin B12 **NA** **ng/l** (200-900)

SF

Serum Folate **NA** **ug/l** (3.1-20.0)

FER

Serum Ferritin **NA** **ug/l** (20-300)

CHI
Number

0502823496

Patient Address 17 ABERCORN STREET
PAISLEY

Clinician DR C MCMAHON

CRN DYK050282349 IRH195834

PA034AA

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 hx ecg abnormality rx methadone

Laboratory Ref.
BL272392DPage
1 of 1

HAEMATOLOGY

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

Date / Time Received 05/02/2013 17:25	Neut 10 ⁹ /L (2.0 - 7.5)	Lymph 10 ⁹ /L (1.5 - 4.0)	Mono 10 ⁹ /L (0.2 - 0.8)	Eos 10 ⁹ /L (0.0 - 0.4)	Baso 10 ⁹ /L (0.01 - 0.10)	Meta	Myelo	Blast	Others	Atypical Lymph	NRBC
Date / Time Reported 05/02/2013 20:36	4.5	1.7	0.7	0.3	0.02						
Date / Time Collected 05/02/2013 u/k	WCC 10 ⁹ /L (4.0 - 11.0)	Hb g/L (130 - 180)	RCC 10 ¹² /L (4.50 - 6.50)	Hct L/L (0.400 - 0.540)	MCV fL (78 - 99)	MCH pg (27.0 - 32.0)	RDW % (11.5 - 14.5)	Retic	Platelets 10 ⁹ /L (150 - 400)	Infectious Mono Screen	ESR mm/hr (0 - 12)
	7.1	140	4.97	0.439	88	28.2	14.1		250		9

CHI
Number

0502823496

Patient Address 151 THRUSHCRAIGS
PAISLEY

Clinician DR C MCMAHON

CRN DYK050282349 IRH195834

PA6 2PP

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 wt loss

Laboratory Ref.
BL253633APage
1 of 1

HAEMATOLOGY

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

Date / Time Received 06/09/2013 11:43	Neut 10 ⁹ /L (2.0 - 7.5)	Lymph 10 ⁹ /L (1.5 - 4.0)	Mono 10 ⁹ /L (0.2 - 0.8)	Eos 10 ⁹ /L (0.0 - 0.4)	Baso 10 ⁹ /L (0.01 - 0.10)	Meta	Myelo	Blast	Others	Atypical Lymph	NRBC
Date / Time Reported 06/09/2013 12:12	3.1	2.8	0.3	0.4	0.04						
Date / Time Collected 06/09/2013 10:15	WCC 10 ⁹ /L (4.0 - 11.0)	Hb g/L (130 - 180)	RCC 10 ¹² /L (4.50 - 6.50)	Hct L/L (0.400 - 0.540)	MCV fL (78 - 99)	MCH pg (27.0 - 32.0)	RDW % (11.5 - 14.5)	Retic	Platelets 10 ⁹ /L (150 - 400)	Infectious Mono Screen	ESR
	6.6	144	4.98	0.450	90	28.9	13.5		262		

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

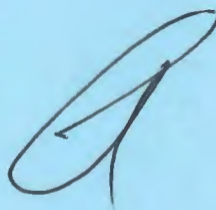
Patient Address **17 ABERCORN STREET PAISLEY**
Clinician **DR C MCMAHON**
Address **Renfrewshire Drug Service
Renfrewshire Drug Service
10 St. James Street
Paisley
, PA3 2HT**

Clinical Details **hx ecg abnormality rx methadone**

Laboratory Ref.
BL272392D

Page
1 of 1

HAEMATOLOGY



Laboratory Number	BL272392D				
Date/Time Specimen	05/02/13 u/k				
I.N.R	0.9				

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

Patient Address **17 ABERCORN STREET PAISLEY**
Clinician **DR C MCMAHON**
Address **Renfrewshire Drug Service
Renfrewshire Drug Service
10 St. James Street
Paisley
, PA3 2HT**

Clinical Details **hx ecg abnormality rx methadone**

Laboratory Ref.
BL272392D

Page
1 of 1

Thrombin Time **12.2** **second** **(11.0 - 15.0)**

HAEMATOLOGY



Date / Time Received **05/02/2013 17:25**
Date / Time Reported **05/02/2013 17:51**

HAEMATOLOGY

Coagulation Screen

Date / Time Collected
05/02/2013 u/k

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

Patient Address **80 BALFRON ROAD
PAISLEY**

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.

BL415920L

1 of 1

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

Date / Time Received	Neut	Lymph	Mono	Eos	Baso	Meta	Myelo	Blast	Others	Atypical Lymph	NRBC
09/05/2012 12:38	10 ⁹ /L (2.0 - 7.5)	10 ⁹ /L (1.5 - 4.0)	10 ⁹ /L (0.2 - 0.8)	10 ⁹ /L (0.0 - 0.4)	10 ⁹ /L (0.01 - 0.10)						
Date / Time Reported 09/05/2012 12:59	4.4	2.4	0.7	0.4	0.03						
	WCC	Hb	RCC	Hct	MCV	MCH	RDW	Retic	Platelets	Infectious Mono Screen	ESR
	10 ⁹ /L (4.0 - 11.0)	g/L (130 - 180)	10 ¹² /L (4.50 - 6.50)	L/L (0.400 - 0.540)	fL (78 - 99)	pg (27.0 - 32.0)	% (11.5 - 14.5)		10 ⁹ /L (150 - 400)		
Date / Time Collected 09/05/2012 11:00	7.9	139	4.86	0.419	86	28.6	13.4		274		

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

Patient Address **17 ABERCORN STREET
PAISLEY**

Clinician **DR C MCMAHON**
 Address **Renfrewshire Drug Service
Renfrewshire Drug Service
10 St. James Street
Paisley
PA3 2HT**

Clinical Details **hx ecg abnormality rx methadone**

Laboratory Ref.

BL272392D

Page

1 of 1

PT	9.4	second	(9.0 - 13.0)
APTT	30.6	second	(27.0 - 38.0)
APTT (Heparin Control)	30.5	second	(49.0 - 81.0)
APTT Ratio	1.0	Ratio	(1.5 - 2.5)

CLYDE HOSPITALS BIOCHEMISTRY REPORT

Surname: **PHILLIPS**
 Forename: **WESLEY**
 DOB/Age: **05.02.82** Sex: **Male**
 CHI/Unit No: **0502823496**
 Address: **14F THRUSHCRAIGS CRESCENT**
 Details: **HEP C ASSESSMENT**

Location: **Renfrewshire Drug Service**
20 Back Sneddon Street
Paisley
Greater Glasgow & Clyde
 Requestor: **Elaine McLellan**
 Ext Labno:

Lab Number	Collected	Received	Glucose mmol/L (3.5-6.0)	HbA1c (IFCC) mmol/mol (20-42)
B,16.7081722.W	26.01.16 14:00	26.01.16 17:07	4.4	
B,15.7542711.S	30.09.15 08:30	30.09.15 20:29	4.9	
B,14.7586637.W	25.11.14 16:15	25.11.14 17:10	6.4*	
B,14.8299843.W	24.10.14 05:11	24.10.14 05:19	5.0	
B,14.7115143.C	26.02.14 02:32	26.02.14 02:51	5.8	

[SC1 Run: 546]

CLYDE HOSPITALS BIOCHEMISTRY REPORT

Surname: **PHILLIPS**
 Forename: **WESLEY**
 DOB/Age: **05.02.82**
 Address: **14F THRUSHCRAIGS CRESCENT**
 Location: **Renfrewshire Drug Service**
 Diagnosis:
 Details: **HEP C ASSESSMENT**

CHI/Unit No: **0502823496**Sex: **Male**Requestor: **Elaine McLellan**

Lab No: **B,16.7081721.H**
 Collected: **26.01.16 14:00**
 Authorised: **27.01.16**

Received: **26.01.16 17:07**
 Authorised by: **Laura Russell CLY BIO**

Alpha-1-Antitrypsin	1.53	g/L
	(1.10-2.10)	
Caeruloplasmin	0.23	g/L
	(0.16-0.47)	
IgG	13.1	g/L
	(6.0-16.0)	
IgA	3.7	g/L
	(0.8-4.0)	
IgM	* 2.6	g/L
	(0.4-2.4)	

C L Y D E H O S P I T A L S
B I O C H E M I S T R Y R E P O R T

Surname: PHILLIPS	Location: Renfrewshire Drug Service
Forename: WESLEY	20 Back Sneddon Street
DOB/Age: 05.02.82 Sex: Male	Paisley
CHI/Unit No: 0502823496	Greater Glasgow & Clyde
Address: 14F THRUSHCRAIGS CRESCENT	Requestor: Elaine McLellan
Details: HEP C ASSESSMENT	Ext Labno:

[[CURRENT]]

Lab Number	B,16.7081721.H	B,15.7419951.S	B,15.7032247.Q
Date/Time collected	26.01.16 14:00	30.09.15 08:30	11.02.15 09:07
Date/Time received	26.01.16 17:07	30.09.15 20:29	11.02.15 11:00

Sodium	mmol/L	(133-146)	140	141	138
Potassium	mmol/L	(3.5-5.3)	5.0	*6.0	4.5
Chloride	mmol/L	(95-108)	104	105	106
Bicarbonate	mmol/L	(22-29)			
Urea	mmol/L	(2.5-7.8)	4.6	3.4	3.5
Creatinine	umol/L	(40-130)	69	74	65
GFR (est'd)	ml/min	(>60)	>60	>60	>60
CRP	mg/L	(0-10)			*22
Magnesium	mmol/L	(0.70-1.00)			
Calcium	mmol/L	(2.20-2.60)		2.38	
Adj Calcium	mmol/L	(2.20-2.60)		2.43	
Phosphate	mmol/L	(0.80-1.50)		1.30	
Albumin	g/L	(35-50)	39	36	
Alk Phos	U/L	(30-130)	81	83	
Tot Bilirubin	umol/L	(<20)	5	4	
Conj Bilirubin	umol/L				
AST	U/L	(<40)	16	23	
ALT	U/L	(<70)	25		

C L Y D E H O S P I T A L S
B I O C H E M I S T R Y R E P O R T

Surname: PHILLIPS	Location: Renfrewshire Drug Service
Forename: WESLEY	20 Back Sneddon Street
DOB/Age: 05.02.82 Sex: Male	Paisley
CHI/Unit No: 0502823496	Greater Glasgow & Clyde
Address: 14F THRUSHCRAIGS CRESCENT	Requestor: Elaine McLellan
Details: HEP C ASSESSMENT	Ext Labno:

Lab Number	Date/Time collected	Date/Time received	AFP	HCG	LDH
			kU/L	U/L	U/L
			(<6)	(<5)	(80-240)
B,16.7081721.H	26.01.16 14:00	26.01.16 17:07	<3		

CLYDE HOSPITALS BIOCHEMISTRY REPORT

Surname: PHILLIPS	Location: South Ward
Forename: WESLEY	Dykebar Hospital
DOB/Age: 05.02.82 Sex: Male	Grahamston Rd Paisley
CHI/Unit No: 0502823496	Greater Glasgow & Clyde
Address: 0/1 51 THRUSHCRAIG CRES	Requestor: BENNIE
Details: OPIATE DEPENDANT	Ext Labno:

[[CURRENT]]				
Lab Number		B,15.7419951.S	B,15.7032247.Q	B,15.7063726.J
Date/Time collected		30.09.15 08:30	11.02.15 09:07	10.02.15 09:33
Date/Time received		30.09.15 20:29	11.02.15 11:00	10.02.15 11:12
Sodium	mmol/L	(133-146) 141	138	138
Potassium	mmol/L	(3.5-5.3) *6.0	4.5	4.6
Chloride	mmol/L	(95-108) 105	106	106
Bicarbonate	mmol/L	(22-29)		
Urea	mmol/L	(2.5-7.8) 3.4	3.5	3.5
Creatinine	umol/L	(40-130) 74	65	72
GFR (est'd)	ml/min	(>60) >60	>60	>60
CRP	mg/L	(0-10)	*22	*47
Magnesium	mmol/L	(0.70-1.00)		
Calcium	mmol/L	(2.20-2.60) 2.38		
Adj Calcium	mmol/L	(2.20-2.60) 2.43		
Phosphate	mmol/L	(0.80-1.50) 1.30		
Albumin	g/L	(35-50) 36		
Alk Phos	U/L	(30-130) 83		
Tot Bilirubin	umol/L	(<20) 4		
Conj Bilirubin	umol/L			
AST	U/L	(<40) 23		
gGT	U/L	(<70)		
ALT	U/L	(<50) 15		
Amylase	U/L	(<100)		
CK	U/L	(40-320)		
Total Protein	g/L	(60-80)		
Globulins	g/L	(23-38)		
Urate	mmol/L	(0.20-0.43)		
Cholesterol	mmol/L			
Triglyceride	mmol/L	(0.2-2.3)		
VLDL Chol	mmol/L			
LDL Chol	mmol/L			
HDL Chol	mmol/L			
Chol/HDL				
TSH	mU/L	(0.35-5.00) 0.50		
Free T4	pmol/L	(9.0-21.0) 18.2		
Total T3	nmol/L	(0.9-2.5)		

Result Comments:

30.09.15 Bone : Alkaline Phosphatase results IFCC aligned from 03/08/15.
 30.09.15 LFTS : Alkaline Phosphatase results IFCC aligned from 03/08/15.

FR 11/10/15

S O U T H G L A S G O W H O S P I T A L S
I M M U N O L O G Y R E P O R T

[CA Run: 556

(Tel 0141 347 8872 / 0141 354 9337)

Surname	PHILLIPS	Location:	Renfrewshire Drug Service
Forename:	WESLEY		20 Back Sneddon Street
DOB/Age:	05.02.82	Sex:	Male
CHI/Unit No:	0502823496		Paisley
Address:	14F THRUSHCRAIGS CRESCENT	Requestor:	Greater Glasgow & Clyde
Diagnosis:		Ext Labno:	Elaine McLellan
Details:			

Lab No: **B,16.3513400.B**

Collected: **26.01.16**

Authorised: **01.02.16**

Received: **27.01.16 15:27**

Authorised by: **Lauren Hennessy**

ANTI-NUCLEAR ANTIBODY (ANA) / CENTROMERE ANTIBODY

ANA screen

Negative

Comments:

I ANA/Centromere Abs: Negative

Date reported: **01.02.16**

CLYDE HOSPITALS BIOCHEMISTRY REPORT

Form: CRGLU Run: 56

Surname: PHILLIPS	Location: South Ward
Forename: WESLEY	Dykebar Hospital
DOB/Age: 05.02.82 Sex: Male	Grahamston Rd Paisley
CHI/Unit No: 0502823496	Greater Glasgow & Clyde
Address: 0/1 51 THRUSHCRAIG CRES	Requestor: BENNIE
Details: OPIATE DEPENDANT	Ext Labno:

Lab Number	Collected	Received	Glucose mmol/L (3.5-6.0)	HbA1c (IFCC) mmol/mol (20-42)
B,15.7542711.S	30.09.15 08:30	30.09.15 20:29	4.9	
B,14.7586637.W	25.11.14 16:15	25.11.14 17:10	6.4*	
B,14.8299843.W	24.10.14 05:11	24.10.14 05:19	5.0	
B,14.7115143.C	26.02.14 02:32	26.02.14 02:51	5.8	

[Signature]
F42 forms.

Result Comments:

CLYDE HOSPITALS
BIOCHEMISTRY REPORT

Surname: PHILLIPS
Forename: WESLEY
DOB/Age: 05.02.82
Address: 0/2 51 THRUSHCRAIG CRESCENT
Location: Renfrewshire Drug Service
Diagnosis:
Details: NO CLINICAL DETAILS ON FORM
Spec. Comm:
External No:

CHI/Unit No: 0502823496

Sex: Male

Requestor: Dr Charles McMahon

Screening Tests

[[CURRENT]]

Lab No B,13.7794923.B
Date/Time collected 03.12.13 11:30
Date/Time received 05.12.13 19:29

Urine Amphetamines Negative

Urine Benzodiazepine Positive

Urine Cocaine Negative

Urine Methadone Positive

Urine Opiates Negative

Urine Cannabinoids

Urine Barbiturates

Urine Alcohol

Urine Buprenorphine

Ur T/cyclic Antideps

Urine Creatinine (mmol/L) 30.0

Result Comments:

CHI
Number

0502823496

Patient Address 151 THRUSHCRAIGS
PAISLEY

Clinician DR C MCMAHON

CRN DYK050282349 IRH195834

PA6 2PP

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 FULL URINE DRUG SCREEN

Laboratory Ref.
BC264309NPage
1 of 1

Amphetamines	Negative	
Benzodiazepine	Positive	
Methadone	Positive	
Opiates	Positive	
Cocaine	Negative	
Urine Creat.	38.20	* 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 07/11/2013 13:03

Date / Time Reported 09/11/2013 09:30

BIOCHEMISTRY

DRUG REPORT

Date / Time Collected

06/11/2013 u/k

Page 1 of 1

CHI
Number

0502823496

Patient Address 151 THRUSHCRAIGS
PAISLEY

Clinician DR C MCMAHON

CRN DYK050282349 IRH195834

PA6 2PP

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 loss

Fasting Laboratory Ref.
N BC253633SPage
1 of 1

Date Reported 06/09/2013	GLUCOSE mmol/L 9.0* (3.5 - 6.0)	SODIUM mmol/L 141 (133 - 146)	POTASSIUM mmol/L 3.6 (3.5 - 5.3)	CHLORIDE mmol/L 106 (95 - 108)	BICARBONATE	UREA mmol/L 4.1 (2.5 - 7.8)	CREATININE umol/L 75 (50 - 120)	eGFR mL/min >60 (60 - 140)
Time Reported 12:36	CRP	ADJ CALCIUM	CALCIUM	PHOSPHATE	MAGNESIUM	URATE	CK	AMYLASE
Date Received 06/09/2013								
Time Received 11:43								
Specimen Type BLOOD	BILIRUBIN umol/L 4 (3 - 21)	ALK PHOS IU/L 87 (30 - 130)	GAMMA GT IU/L 35 (0 - 70)	AST IU/L 15 (10 - 45)	ALT IU/L 12 (5 - 55)	TOTAL PROTEIN	ALBUMIN g/L 37 (35 - 50)	GLOBULINS

AUTHORISED BY DUTY CLINICIAN/SCIENTIST

? known diabetic.

Pass to GP if
not known.

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

BIOCHEMISTRY

ALCO,GGT,GLU,RTN,SBF

Date / Time Collection
06/09/2013 10:15

Page 1 of 1

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

Patient Address **151 THRUSHCRAIGS PAISLEY**
Clinician **DR C MCMAHON**
Address **Renfrewshire Drug Service
Renfrewshire Drug Service
10 St. James Street
Paisley
, PA3 2HT**

Laboratory Ref. **BC253633S** Page **1 of 1**

Alcohol

Not dete

Authorised by Duty Clinician/Scientist

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

Date / Time Received 06/09/2013 11:43

Date / Time Reported 06/09/2013 15:37

BIOCHEMISTRY

ALCO,GGT,GLU,RTN,SBF

Date / Time Collected

06/09/2013 10:15

Page 1 of 1

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

Patient Address **151 THRUSHCRAIGS PAISLEY**
Clinician **DR C MCMAHON**
Address **Renfrewshire Drug Service
Renfrewshire Drug Service
10 St. James Street
Paisley
, PA3 2HT**

Laboratory Ref. **BC253633S** Page **1 of 1**

Vitamin B12 339 ng/L (180 - 1000) (a)
Serum Folate * 1.7 ug/L (3.0 - 20.0) (b)
(a) Normal vitamin B12 level.
Reference range changed 25/10/12.
(b) Low folate. Consider poor diet, malabsorption
or increased demand as possible causes. Before
considering Rx, please repeat to confirm and
ensure co-existent B12 deficiency has been
excluded.
Reference range changed 25/10/12.

Script ✓

Authorised by Duty Clinician/Scientist

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

Date / Time Received 06/09/2013 11:43

Date / Time Reported 06/09/2013 13:07

BIOCHEMISTRY

ALCO,GGT,GLU,RTN,SBF

Date / Time Collected

06/09/2013 10:15

Page 1 of 1

CHI Number **0502823496**
CRN **DYK050282349 IRH195834** PA034AA
Surname **PHILLIPS** Sex **Male**
Forename **WESLEY** Date of Birth **05/02/1982**

Patient Address 17 ABERCORN STREET
PAISLEY

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.
BC006554S

Page
1 of 1

Amphetamines	Negative		
Benzodiazepine	Negative		
Methadone	Positive		
Opiates	Negative		
Cocaine	Negative		
Urine Creat.	14.80	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 04/06/2013 15:47
Date / Time Reported 06/06/2013 09:30

BIOCHEMISTRY

DRUG REPORT

Date / Time Collected
03/06/2013 u/k

Page 1 of 1

CHI Number **0502823496**
CRN **DYK050282349 IRH195834** PA6 2PP
Surname **PHILLIPS** Sex **Male**
Forename **WESLEY** Date of Birth **05/02/1982**

Patient Address 151 THRUSHCRAIGS
PAISLEY

Clinician **DR C MCMAHON**
Address **Renfrewshire Drug Service**
Renfrewshire Drug Service
10 St. James Street
Paisley
, PA3 2HT

Clinical Details DATE ON FORM 28/6/13

Laboratory Ref.
BC021696F

Page
1 of 1

Amphetamines	Negative		
Benzodiazepine	Positive		
Methadone	Positive		
Opiates	Positive		
Cocaine	Negative		
Urine Creat.	37.30	* 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 08/07/2013 10:40
Date / Time Reported 09/07/2013 09:30

BIOCHEMISTRY

DRUG REPORT

Date / Time Collected
08/07/2013 u/k

Page 1 of 1

CHI Number **0502823496**
CRN **DYK050282349 IRH195834**
Surname **PHILLIPS** Sex **Male**
Forename **WESLEY** Date of Birth **05/02/1982**
Clinical Details **FDS**
Patient Address **17 ABERCORN STREET PAISLEY**
Clinician **DR C MCMAHON**
Address **Renfrewshire Drug Service
Renfrewshire Drug Service
10 St. James Street
Paisley
, PA3 2HT**
Laboratory Ref. **BC279937F**
Page **1 of 1**

Amphetamines Negative
Benzodiazepine Positive
Methadone Positive
Opiates Positive
Cocaine Negative
Urine Creat. 22.00 * 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 12/02/2013 13:09
Date / Time Reported 13/02/2013 09:30

BIOCHEMISTRY

DRUG REPORT

Date / Time Collected

12/02/2013 u/k

Page 1 of 1

CHI Number **0502823496**
CRN **DYK050282349 IRH195834**
Surname **PHILLIPS** Sex **Male**
Forename **WESLEY** Date of Birth **05/02/1982**
Clinical Details **DATE ON FORM 7/5/13**
Patient Address **17 ABERCORN STREET PAISLEY**
Clinician **DR C MCMAHON**
Address **Renfrewshire Drug Service
Renfrewshire Drug Service
10 St. James Street
Paisley
, PA3 2HT**
Laboratory Ref. **BC423177V**
Page **1 of 1**

Amphetamines Consistent with depleted iron stores.
Benzodiazepine Regret discarded before analysis completed
Methadone Regret discarded before analysis completed
Opiates Regret discarded before analysis completed
Cocaine Regret discarded before analysis completed
Urine Creat. 22.20 * 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 14/05/2013 16:04
Date / Time Reported 05/06/2013 09:30

BIOCHEMISTRY

DRUG REPORT

Date / Time Collected

14/05/2013 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 **17 ABERCORN STREET PAISLEY**
Clinician **DR C MCMAHON**
Address **Renfrewshire Drug Service
Renfrewshire Drug Service
10 St. James Street
Paisley
, PA3 2HT**

Clinical Details **hx ecg abnormality rx methadone**

Laboratory Ref.

BC272392F

Page

1 of 1

Cholesterol	* 5.3	mmol/L	(3.1 - 5.0)	
Triglycerides	1.7	mmol/L	(0.0 - 2.3)	
Ferritin	71	ug/L	(15 - 275)	(a)
TSH	0.62	mu/L	(0.35 - 4.0)	(b)
Free T4	14.2	pmol/L	(9.0 - 21.0)	
Vitamin B12	312	ng/L	(180 - 1000)	(c)
Serum Folate	3.0	ug/L	(3.0 - 20.0)	(d)

(a) Normal Ferritin.

Reference range changed 25/10/12.

(b) Euthyroid levels.

(c) Normal vitamin B12 level.

Reference range changed 25/10/12.

(d) Normal serum Folate level.

Reference range changed 25/10/12.

Authorised by Duty Clinician/Scientist

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

Date / Time Received 05/02/2013 17:25

Date / Time Reported 05/02/2013 19:07

BIOCHEMISTRY

ALCO,AMY,BONE,CK,CRP,FERR,GLU,

Date / Time Collected

05/02/2013 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 **17 ABERCORN STREET PAISLEY**
Clinician **DR C MCMAHON**
Address **Renfrewshire Drug Service
Renfrewshire Drug Service
10 St. James Street
Paisley
, PA3 2HT**

Clinical Details **hx ecg abnormality rx methadone**

Laboratory Ref.

BC272392F

Page

1 of 1

Troponin I <0.04 ug/L (0 - 0.04) (a)

Alcohol Not dete

(a) No biochem evidence of recent myocardial injury

Authorised by Duty Clinician/Scientist

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

Date / Time Received 05/02/2013 17:25

Date / Time Reported 05/02/2013 19:22

BIOCHEMISTRY

ALCO,AMY,BONE,CK,CRP,FERR,GLU,

Date / Time Collected

05/02/2013 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 **17 ABERCORN STREET PAISLEY**
 Address **Renfrewshire Drug Service**
Renfrewshire Drug Service
10 St. James Street
Paisley
, PA3 2HT

Clinical Details **fds** Laboratory Ref. **BC247202L** Page **1 of 1**

Amphetamines Negative
 Benzodiazepine Positive
 Methadone Positive
 Opiates Negative
 Cocaine Negative
 Urine Creat. 25.70 * 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 16/01/2013 16:46

Date / Time Reported 19/01/2013 09:30

BIOCHEMISTRY

DRUG REPORT

Date / Time Collected
15/01/2013 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 **17 ABERCORN STREET PAISLEY**
 Address **Renfrewshire Drug Service**
Renfrewshire Drug Service
10 St. James Street
Paisley
, PA3 2HT

Clinical Details **hx ecg abnormality rx methadone** Fasting **N** Laboratory Ref. **BC272392F** Page **1 of 1**

Date Reported	GLUCOSE mmol/L	SODIUM mmol/L	POTASSIUM mmol/L	CHLORIDE mmol/L	BICARBONATE	UREA mmol/L	CREATININE umol/L	eGFR mls/min
05/02/2013	5.7 (3.5 - 6.0)	140 (133 - 146)	4.1 (3.5 - 5.3)	108 (95 - 108)		3.2 (2.5 - 7.8)	69 (50 - 120)	>60 (60 - 140)
Date Received	CRP mg/L	ADJ CALCIUM mmol/L	CALCIUM mmol/L	PHOSPHATE mmol/L	MAGNESIUM mmol/L	URATE mmol/L	CK IU/L	AMYLASE IU/L
05/02/2013	5 (0 - 10)	2.41 (2.20 - 2.60)	2.36 (2.10 - 2.60)	0.77* (0.80 - 1.50)	0.85 (0.70 - 1.00)	0.36 (0.16 - 0.45)	323* (40 - 320)	60 (0 - 100)
Time Received	BILIRUBIN umol/L	ALK PHOS IU/L	GAMMA GT	AST IU/L	ALT IU/L	TOTAL PROTEIN	ALBUMIN g/l	GLOBULINS
17:25	5 (3 - 21)	92 (30 - 130)		31 (10 - 45)	39 (5 - 55)		40 (35 - 50)	
Specimen Type	BLOOD							

AUTHORISED BY DUTY CLINICIAN/SCIENTIST

Normal Troponin
 How old was Chest Pain?

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

BIOCHEMISTRY

ALCO, AMY, BONE, CK, CRP, FERR, GLU,

Date / Time Collection
05/02/2013 u/k

Page 1 of 1

ROYAL ALEXANDRA HOSPITAL BIOCHEMISTRY DEPARTMENT 0141 314 6157 80

CHI Number **0502823496** Patient Address **80 BALFRON ROAD PAISLEY** Clinician **DR C MCMAHON**

CRN **DYK050282349 IRH195834** PA013HD 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.** Fasting **No** Laboratory Ref. **BC415920C** Page **1 of 1**

Date Reported 09/05/2012	GLUCOSE	SODIUM mmol/L 139 (133 - 146)	POTASSIUM mmol/L 4.5 (3.5 - 5.3)	CHLORIDE mmol/L 110* (95 - 108)	BICARBONATE mmol/L 22 (22 - 29)	UREA mmol/L 5.4 (2.5 - 7.8)	CREATININE umol/L 66 (50 - 120)	eGFR mls/min >60 (60 - 140)
Time Reported 14:40	CRP	ADJ CALCIUM mmol/L 2.42 (2.20 - 2.60)	CALCIUM mmol/L 2.32 (2.10 - 2.60)	PHOSPHATE mmol/L 0.91 (0.80 - 1.50)	MAGNESIUM mmol/L 0.96 (0.70 - 1.00)	URATE	CK	AMYLASE
Date Received 09/05/2012								
Time Received 12:38								
Specimen Type BLOOD	BILIRUBIN umol/L 4 (3 - 21)	ALK PHOS IU/L 109 (30 - 130)	GAMMA GT IU/L 36 (0 - 70)	AST IU/L 44 (10 - 45)	ALT IU/L 62* (5 - 55)	TOTAL PROTEIN g/L 69 (60 - 80)	ALBUMIN g/L 37 (35 - 50)	GLOBULINS g/L 32 (23 - 38)

AUTHORISED BY DUTY CLINICIAN/SCIENTIST

[Handwritten Signature] ? Hep C status.
d/t ↑ AST (mild)

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

BIOCHEMISTRY **BONE, FERR, GGT, MG, RTN, SBF** Date / Time Collection **09/05/2012 11:00** Page **1 of 1**

ROYAL ALEXANDRA HOSPITAL BIOCHEMISTRY DEPARTMENT 0141 314 6157 RCDRU 66

CHI Number **0502823496** Patient Address **17 ABERCORN STREET PAISLEY** Clinician **DR C MCMAHON**

CRN **DYK050282349 IRH195834** PA034AA 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 **fds no name on spec** Laboratory Ref. **BC151099F** Page **1 of 1**

Amphetamines No Name on sample.
Benzodiazepine No Name on sample.
Methadone No Name on sample.
Opiates No Name on sample.
Cocaine No Name on sample.
Urine Creat. No Name on sample.

Authorised by Duty Clinician/Scientist Date / Time Received **01/11/2012 09:52**
Normal Adult Reference Ranges are for Guidance Only. They do not take into account age difference. Date / Time Reported **02/11/2012 09:30**

BIOCHEMISTRY **DRUG REPORT** Date / Time Collected **18/10/2012 13:30** Page **1 of 1**

CHI
Number

0502823496

Patient Address 17 ABERCORN STREET
PAISLEY

Clinician Unknown

CRN DYK050282349 IRH195834

PA034AA

Address Renfrewshire Drug Service
Renfrewshire Drug Service
10 St. James Street
Paisley
, PA3 2HT

Surname PHILLIPS

Sex Male

Forename WESLEY

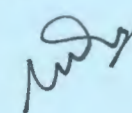
Date of Birth 05/02/1982

Clinical Details No clinical details provided.

Laboratory Ref.
BC077042VPage
1 of 1Amphetamines
Benzodiazepine
Methadone
Opiates
Cocaine
Urine Creat.Negative
Positive
Positive
Positive
Negative
17.80

* 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 17/08/2012 16:36

Date / Time Reported 21/08/2012 09:30

BIOCHEMISTRY

DRUG REPORT

Date / Time Collected

13/08/2012 u/k

Page 1 of 1

CHI
Number

0502823496

Patient Address 80 BALFRON ROAD
PAISLEY

Clinician DR C MCMAHON

CRN DYK050282349 IRH195834

PA013HD

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.
BC415920CPage
1 of 1

Ferritin	85	ug/L	(30 - 400)	(a)
Vitamin B12	358	ng/L	(187 - 883)	(b)
Serum Folate	4.2	ug/L	(2.6 - 14.8)	(c)
(a)	Normal Ferritin.			
(b)	Normal vitamin B12 level.			
(c)	Normal serum Folate level.			



Authorised by Duty Clinician/Scientist

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

Date / Time Received 09/05/2012 12:38

Date / Time Reported 09/05/2012 14:37

BIOCHEMISTRY

BONE,FERR,GGT,MG,RTN,SBF

Date / Time Collected

09/05/2012 11:00

Page 1 of 1

S O U T H G L A S G O W H O S P I T A L S
I M M U N O L O G Y R E P O R T

A Run: 576

(Tel 0141 347 8872 / 0141 354 9337)

Surname	PHILLIPS	Location:	Renfrewshire Drug Service
Forename:	WESLEY		20 Back Sneddon Street
DOB/Age:	05.02.82	Sex:	Male
CHI/Unit No:	0502823496		Paisley
Address:	14F THRUSHCRAIGS CRESCENT	Requestor:	Greater Glasgow & Clyde
Diagnosis:		Ext Labno:	Elaine McLellan
Details:			

Lab No: B,16.3513400.B
Collected: 26.01.16
Authorised: 03.02.16

Received: 27.01.16 15:27
Authorised by: Frances Henriquez IMM

AUTOANTIBODIES (LIVER & GASTRIC PARIETAL CELL)

Mitochondrial ab	Negative
Smooth Muscle ab	Negative
Gastric Parietal Cel	Negative
LKM abs	Negative
Liver Cytosol 1 ab	Negative

Comments:

I Autoantibodies: Test performed on mouse tissue

LKM abs = Liver kidney microsomal abs

LC1 abs = Liver cytosolic antigen type 1 abs

*No action
File*

BOW 5/2/16

Date reported: 03.02.16

NAME NESLEY PHILLIPS		CHI (10 digits) 0502823496		WARD/HOSPITAL		CONSULTANT Dr Mr Maher		DATE REWRITTEN						
REGULAR PRESCRIPTIONS					TIMES (24 hour)				OTHER TIMES		PRESCRIBER'S SIGNATURE		DISCONTINUED	
PHARMACY	START DATE	MEDICINE (Block letters) - APPROVED NAME	DOSE	ROUTE	0900	1300	1700	2200					DATE	INITIALS
A	8/10/15	Methadone liquid	30mg	PO	Daily Dispense				[Signature]			15/10/15	BW	
B	15/10/15	METHADONE	40mg	O	Daily Dispense				[Signature]			21/10	B	
C	15/10/15	QUETIAPINE	50mg	O	Daily Dispense				[Signature]			21/10	B	
D	22/10/15	METHADONE	30mg	PO	Daily Dispense				[Signature]			28/10/15	B	
E	22/10/15	QUETIAPINE	150mg	PO	Daily Dispense				[Signature]			15/11	C	
F	29/10/15	METHADONE	60mg	PO	Daily Dispense				[Signature]			4/11	C	
G	4/11/15	METHADONE	70mg	O	Daily Dispense				[Signature]			15/11	C	
H	4/11/15	METHADONE	80	O	Daily Dispense				[Signature]			23/11/15	BW	
I	10/11/15	QUETIAPINE	200mg	O	Daily Dispense				[Signature]					
K	23/11/15	METHADONE	90mg	O	Daily Dispense				[Signature]					
L														
M														
N														
O														
P														
AS REQUIRED PRESCRIPTIONS		DOSE	ROUTE	INDICATION	DOSE INTERVAL		MAX DOSE IN 24HRS							
Q														
R														
S														
T														
V														
W														
DEPOTS/LONG-ACTING INJECTIONS		DOSE		FREQUENCY										
X														
Y														
Z														
DATE	ONCE ONLY MEDICATIONS	DOSE	ROUTE	TIME	SIGNATURE	GIVEN BY	TIME GIVEN	ADDITIONAL INFORMATION						
APPROPRIATE ALERT STICKERS														
HIGH DOSE ANTIPSYCHOTIC THERAPY		T2/T3		RISK OF INFECTION		KNOWN ALLERGY/ADVERSE DRUG REACTION - DETAILS								

te: 8/10/15
 ame: Wesley Phillips
 OB: 05-02-82
 dress: 0/2 51
Thompson &
General. PAB 6PP
 41: 3496
 VIFT: 10072527

Keyworker: Jax
 Change of KW: _____
 Prescribing Dr: McNabon
 Change of Dr: _____
 Change of Dr: _____
 GP: Johnstone
 Add: Money
 Tel: _____

Chemist: Lloyds
 Address: Newtown RD
 Tel: 889 2216
 Change of Chemist: _____
 Address: _____
 Tel: _____

Drug	ext due	Dose	No days	Special Instructions	Script no	Issued by	Date of Issue
<i>methadone</i>							
	8/10/15	30mb		<i>daily ruf</i>	93063479620	<i>Q</i>	8/10/15
	15/10/15	40mb		<i>"</i>	92873620683	<i>Q</i>	15/10/15
	22/10/15	50mb		<i>"</i>	93063224493	<i>Q</i>	22/10/15
	29/10/15	60mb		<i>"</i>	92873879596	<i>Q</i>	29/10/15
	5.11.15	70	5	<i>"</i>	92873756350	<i>GM</i>	5.11.15
	10/11/15	80	7	<i>"</i>	930632722462	<i>Q</i>	10/11/15
	17/11/15	90	7	<i>"</i>	92873742087	<i>Q</i>	17/11/15
	24/11/15	90	7	<i>"</i>	9287387832	<i>Q</i>	24/11/15
	1/12/15	90	7	<i>"</i>	94089823400	<i>Q</i>	2/12/15
	8/12/15	90	7	<i>"</i>	3437	<i>Q</i>	8/12/15

Drug	ext due	Dose	No Days	Special Instructions	Script no	Issued by	Date of Issue
<i>gabapentin</i>							
	15/10/15	50mg	7		92873755938	<i>Q</i>	15/10/15
	22/10/15	4x200mg	7		93063224484	<i>Q</i>	22/10/15
	29/10/15	4x200mg	7		928738779587	<i>Q</i>	29/10/15
	5.11.15	4x200mg	5		92873756340	<i>GM</i>	5.11.15
	10/11/15	200mg	7		93063272453	<i>Q</i>	10/11/15
	17/11/15	200mg	7		92873742078	<i>Q</i>	17/11/15
	24/11/15	200mg	7		93063269674	<i>Q</i>	24/11/15
	1/12/15	200mg	7		3378	<i>Q</i>	2/12/15
	8/12/15	200mg	7		3381	<i>Q</i>	8/12/15
	15/12/15	200mg	7		3390	<i>Q</i>	15/12/15
	22/12/15	"	7		3327	<i>Q</i>	15/12/15
	29/12/15	"	7		3345	<i>Q</i>	30/12/15
	5/1/16	"	7		3354	<i>Q</i>	30/12/15
	12/1/16	"	7		3363	<i>Q</i>	12/1/16
	19/1/16	"	7		3336	<i>Q</i>	12/1/16

NAME Wesley Phillips	CHI (10 digits) N08-05102182	WARD/HOSPITAL R05	CONSULTANT Dr McManus	DATE REWRITTEN 9/4/14
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REGULAR PRESCRIPTIONS					TIMES (24 hour)				OTHER TIMES		PREScriBER'S SIGNATURE	DISCONTINUED	
PHARMACY	START DATE	MEDICINE (Block letters) - APPROVED NAME	DOSE	ROUTE	0900	1300	1700	2200				DATE	INITIALS
A	8/11/11	Methadone oral solution	60ml	oral	daily			sup			for	8/5/12	LM
B	8/11/11	Quetiapine	300mg	oral	✓						for	8/2/12	LM
C	8/11/11	Phenelzine	40mg	oral	✓						for	14/2/12	LM
D	9/2/12	Quetiapine	300mg	oral					✓		for	14/2/12	LM
E	14/2/12	Phenelzine	20mg	oral							for	8/5/12	LM
F	14/2/12	Quetiapine	150mg	oral	✓						for	4/5/12	LM
G	4/5/12	Diazepam	5mg	po	✓			✓	(see notes)		for	26/6/12	LM
H	8/5/12	Methadone as mylun	50mg	oral	daily			sup			for		
I	22/5/12	Seconal	50mg	oral	✓						for	26/6	c
K	26/6/12	Diazepam	5mg	o				✓	x 2wks		for	26/6	c
L	26/6/12	SERTALINE	100mg	(oral)	stop			sup	x 2wks		for		
M	26/6/12	SERTALINE	100mg	p.o.	✓						ce	4/12	c
N	4/11/12	SERTALINE	150mg		✓						ce		
O	8/4/14	NEURILENE	5g								ce		
P													
Q		AS REQUIRED PRESCRIPTIONS	DOSE	ROUTE	INDICATION	DOSE INTERVAL		MAX DOSE IN 24HRS					
R													
S													
T													
V													
W													
X		DEPOTS/LONG-ACTING INJECTIONS	DOSE		FREQUENCY								
Y													
Z													
	DATE	ONCE ONLY MEDICATIONS	DOSE	ROUTE	TIME	SIGNATURE		GIVEN BY		TIME GIVEN	ADDITIONAL INFORMATION		

APPROPRIATE ALERT STICKERS			
HIGH DOSE ANTIPSYCHOTIC THERAPY	T2/T3	RISK OF INFECTION	KNOWN ALLERGY/ADVERSE DRUG REACTION - DETAILS

m. Blackwood

FORWARD PLANNER						
Contact Patient Full Name	Next Appointment	Medication	Dose	No of Days	Installment Wording	Installment wording (Other Dispensing) Non Controlled Drugs
0502823496 Wesley Phillips	1/7/14	MSTADONE	50	28	Supply <u>50</u> ml Daily. <u>100</u> ml on <u>SAT</u> ml on ____ ml on ____ Supervised On Day of collection.	
		Sepraxline	50	28	Supply <u>50</u> ml Daily. <u>100</u> ml on <u>SAT</u> ml on ____ ml on ____ Supervised On Day of collection.	
		Sepraxline	100	28	Supply <u>100</u> ml Daily. <u>200</u> ml on <u>SAT</u> ml on ____ ml on ____ Supervised On Day of collection.	
		ARIP. Penzole	5	28	Supply <u>5</u> ^{mg} ml Daily. <u>10</u> ^{mg} ml on <u>SAT</u> ml on ____ ml on ____ Supervised On Day of collection.	
					Supply ____ ml Daily. ____ ml on ____ ml on ____ ml on ____ Supervised On Day of collection.	
					Supply ____ ml Daily. ____ ml on ____ ml on ____ ml on ____ Supervised On Day of collection.	

Prescription Record

Name: Wesley Phillips
D.O.B: 05 02 82
Address: 6/2 St THROSVICK
PAISLEY
PA 6 2PP
Date: _____
Change
of Add: _____

C.H.I: 3496
SWIFT: _____

Date: _____
 Keyworker: M. Parkinson
 Change of Keyw: _____
 Prescribing Dr: M. Maltin
 Change of Dr: _____
 Change of Dr: _____
 GP: Johnstone
 Add: Nethercroft
 Phone: 889 3732
 Change of GP: _____

Date: _____

Chemist: Lloyds

Address: Causey Side St

Phone No: _____

Change of

Chemist: _____

Address: _____

Phone No: _____

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

Other instructions: _____

[illegible][illegible]

NAME WESLEY PHILLIPS		CHI (10 digits) 050 282 3496	WARD/HOSPITAL RDS		CONSULTANT		DATE REWRITTEN	
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REGULAR PRESCRIPTIONS										PRESCRIBER'S SIGNATURE		DISCONTINUED	
PHARMACY	START DATE	MEDICINE (Block letters) - APPROVED NAME	DOSE	ROUTE	TIMES (24 hour)				OTHER TIMES		DATE	INITIALS	
					0900	1300	1700	2200					
A	16.9.14	10ml	10ml	0	daily				as per				
B													
C													
D													
E													
F													
G													
H													
J													
K													
L													
M													
N													
O													
P													
		AS REQUIRED PRESCRIPTIONS	DOSE	ROUTE	INDICATION		DOSE INTERVAL		MAX DOSE IN 24HRS				
Q													
R													
S													
T													
V													
W													
		DEPOTS/LONG-ACTING INJECTIONS	DOSE		FREQUENCY								
X													
Y													
Z													
DATE	ONCE ONLY MEDICATIONS		DOSE	ROUTE	TIME	SIGNATURE		GIVEN BY	TIME GIVEN	ADDITIONAL INFORMATION			

APPROPRIATE ALERT STICKERS

HIGH DOSE ANTIPSYCHOTIC THERAPY	T2/T3	RISK OF INFECTION	KNOWN ALLERGY/ADVERSE DRUG REACTION - DETAILS
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DATE	REGULAR PRESCRIPTIONS TIMES (24 hour)				OTHER TIMES			AS REQUIRED			DEPOT	COMMENTS/ DISCREPANCIES
	0900	1300	1700	2200				TIME	TIME	TIME		
29/9/15	A	A	A	A				TIME 2:00 PM	TIME 2:00 PM	TIME 2:00 PM		
	SIGN	SIGN	SIGN	SIGN	SIGN	SIGN	SIGN	SIGN	SIGN	SIGN		
	SIGN	SIGN	SIGN	SIGN	SIGN	SIGN	SIGN	SIGN	SIGN	SIGN		
30/9/15	A	A	A	A				TIME 15:30	TIME	TIME		
	SIGN	SIGN	SIGN	SIGN	SIGN	SIGN	SIGN	SIGN	SIGN	SIGN		
	SIGN	SIGN	SIGN	SIGN	SIGN	SIGN	SIGN	SIGN	SIGN	SIGN		
1-10-15	A	(A)	A	A				TIME 18:45	TIME	TIME		
	SIGN	SIGN	SIGN	SIGN	SIGN	SIGN	SIGN	SIGN	SIGN	SIGN		
	SIGN	SIGN	SIGN	SIGN	SIGN	SIGN	SIGN	SIGN	SIGN	SIGN		
2-10-15	A		A	A				TIME 2:30 PM	TIME	TIME		
	SIGN	SIGN	SIGN	SIGN	SIGN	SIGN	SIGN	SIGN	SIGN	SIGN		
	SIGN	SIGN	SIGN	SIGN	SIGN	SIGN	SIGN	SIGN	SIGN	SIGN		
3/10/15	A			A				TIME	TIME	TIME		
	SIGN	SIGN	SIGN	SIGN	SIGN	SIGN	SIGN	SIGN	SIGN	SIGN		
	SIGN	SIGN	SIGN	SIGN	SIGN	SIGN	SIGN	SIGN	SIGN	SIGN		
4/10/15	A							TIME 11:55	TIME	TIME		
	SIGN	SIGN	SIGN	SIGN	SIGN	SIGN	SIGN	SIGN	SIGN	SIGN		
	SIGN	SIGN	SIGN	SIGN	SIGN	SIGN	SIGN	SIGN	SIGN	SIGN		
5-10-15	A							TIME	TIME	TIME		
	SIGN	SIGN	SIGN	SIGN	SIGN	SIGN	SIGN	SIGN	SIGN	SIGN		
	SIGN	SIGN	SIGN	SIGN	SIGN	SIGN	SIGN	SIGN	SIGN	SIGN		

NAME
WESLEY PHILIPS

CHI (10 digits)
0508823496

WARD/HOSPITAL
South Dyrkova

CONSULTANT
DR BERNIE

Circle letter eg. (A) if medicine not given
Document reason in comments/discrepancies

NAME WESLEY PHILLIPS	CHI (10 digits) 0502823496	WARD/HOSPITAL SOUTH/DYKESAR	CONSULTANT BENNIE	DATE REWRITTEN
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REGULAR PRESCRIPTIONS					TIMES (24 hour)				OTHER TIMES			PRESCRIBER'S SIGNATURE	DISCONTINUED	
PHARMACY	START DATE	MEDICINE (Block letters) - APPROVED NAME	DOSE	ROUTE	0900	1300	1700	2200					DATE	INITIALS
A	29/9/15	Dihydrocodone reductingresine	(see chart)	PO								JWELLIS		
B														
C														
D														
E														
F														
G														
H														
I														
J														
K														
L														
M														
N														
O														
P														

AS REQUIRED PRESCRIPTIONS		DOSE	ROUTE	INDICATION	DOSE INTERVAL	MAX DOSE IN 24HRS	
Q	28/9/15	SYMPTOMATIC RELIEF PROTOCOL	A) PER POLICY				W240M04
R	28/9/15	LORAZEPAM	2MG	PO	AGITATION	2°	8MG W240M04
S	28/9/15	ZOPICLONE	7.5MG	PO	INSOMNIA	24°	7.5MG W240M04
T	28/9/15	Dihydrocodone	30mg	PO	withdrawn	11-6 (see sheet)	780mg JWELLIS
V	28/9/15	dihydrocodone	30mg	PO	withdrawn	4-6°	240mg (see A) JWELLIS (240mg)

DEPOTS/LONG-ACTING INJECTIONS		DOSE	FREQUENCY
X			
Y			
Z			

DATE	ONCE ONLY MEDICATIONS	DOSE	ROUTE	TIME	SIGNATURE	GIVEN BY	TIME GIVEN	ADDITIONAL INFORMATION

APPROPRIATE ALERT STICKERS			
HIGH DOSE ANTI-PSYCHOTIC THERAPY	T2/T3	RISK OF INFECTION	KNOWN ALLERGY/ADVERSE DRUG REACTION - DETAILS