NHS GREATER GLASGOW & CLYDE - MENTAL HEALTH CARE PLAN

PERSONAL DATA SHEET

NHS Greater Glasgow and Clyde

PIMS NO/CHI NO:	0502823496	WARD:	LANGHILL AAU.
NAME:	Wesley Phillips		
ADDRESS:	Inverclyde Centre		
POST CODE:			
DOB & GENDER:			

PATIENT CONTACT DETAILS			
TELEPHONE:		MOBILE:	07464218580

PERSONAL DETAILS			
NEED FOR INTERPRETER:	YES / (NO)	PREFERRED LANGUAGE OR METHOD OF COMMUNICATION	ENGLISH / VERBAL
NATIONALITY:	BRITISH		
PREFERRED NAME:	Wesley	MAIDEN NAME:	
OCCUPATION:	Unemployed	NATIONAL INSURANCE NO:	UNKNOWN
SOURCE OF INCOME:	Benefits	RELIGION:	PROTESTANT

MARITAL STATUS
(PLEASE CIRCLE BELOW AS APPROPRIATE, IF OTHER PLEASE STATE)

SINGLE	MARRIED	SEPARATED	DIVORCED	WIDOWED	OTHER

MEDICAL ALERTS
E.G. ALLERGIES

NONE KNOWN BY PATIENT

NHS GREATER GLASGOW & CLYDE - MENTAL HEALTH CARE PLAN

MENTAL HEALTH & CRIMINAL PROCEDURES ACTS INFORMATION

PIMS NO/CHI NO:	0502823496	**WARD:**	AAU
NAME:	Wesley Phillips		
ADDRESS:	C/O Inverclyde Centre		
POST CODE:			
DOB & GENDER:	05/02/82.		

LOCATION/ SERVICE	MH/CPA ACT LEGAL STATUS	DATE & TIME EXPIRES (WHERE APPROPRIATE)	PRINT NAME/SIGN & GIVE DATE AND TIME	
			VERBAL EXPLANATION GIVEN	MENTAL WELFARE CO
	INFORMAL			

Mental Health Partnership
Clinical Risk Screening and Management Tool

NHS Greater Glasgow and Clyde

Service Users Name:	Chi No / DoB:	PIMS No:
WESLEY PHILLIPS	5/2/82.	
Legal Status: Informal ☑ Detained ☐ Community Order ☐	**Ward / Dept / CMHT:** IRH A+E.	

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 EMIS. PMS	

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:	Signature:
EDDIE MACKAY	
Designation: OOH CPN	**Date & Time** 13/1/17. 03:00hrs

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Clinical Risk Screening and Management Tool

NHS Greater Glasgow and Clyde

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

NHS Greater Glasgow and Clyde

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

Management plan	Action by:
Suicide/Self Harm Refer for Duty Psychiatric Assessment	
Violence As Above	
Other Risk Factors As Above	

Outcome of screening/management plan discussed with

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

Management Plan completed by

Print name: Eddie Urquhart	Signature:
Designation: DOH CPN	Date & Time 13/1/17. 03-00hrs

3. Mental State Assessment:

Will Include:	**Appearance/Behaviour, mood, Suicidal Ideation, Psychotic symptoms, Cognitive functioning, Thought process and insight**
May Include:	**Sleep, Appetite, Relevant substance abuse, Relevant personal history**

BROUGHT TO A&E BY POLICE. Seen on CCTV ingesting tablets
Brother in attendance when we arrived.
Assessed 6 days ago by OOH GPs when he walked out and brother then became hostile to staff.
seen by Dr Loudon Crown house on 30th Nov.
seen by OOH crisis on 7th.
seen by Inverclyde crisis then overdosed & admitted medically on 10th.
Reports previously prescribed Largactil 600mg & quetiapine 600mg. States he had diagnosis of Tourettes when younger. Attended specialist centre in Birmingham where he was diagnosed with emotionally unstable personality.

Tonight Dressed in loungewear, unshaved, sitting upright on hospital trolley. Overweight. Quietly spoken, maintained eye contact throughout - intense and therefore inappropriate.
No signs of agitation, no distraction
No obvious thought disorder - able to converse freely + respond to questions appropriately
He gave account of voice of god telling him to take 10 packs of paracetamol
He did not think it strange or that he would draw attention to himself by asking shoppers to get him some, or to ingest them on site.
Vague about voice, but consistent with account.
States the voice was forceful. Didn't dispute that the voice may be his own thought, but then questioned why voice would be the same as his thought.
Doesn't want to end his life, but maintains that he must do as god commands.
Did not expect anything from tonight.
Did not allude to hospital admission.
States voices are persistent and has to comply.
Mood subjectively & objectively low.
Flat affect.
No illicit substances for 1 year. Alcohol earlier.
Impression - Gentleman didn't seem to have skills to challenge own thoughts

Summary

Possible learning difficulty.
Maintains that he had to try and take his life, Does not want to thought.
Lacks motivation to change - has remained in homeless for 3 months. Sleeps a lot.
Seems unable to differentiate between thoughts & perceived voice.
? Thoughts driven by low mood
Unwilling to accept instruments of change as suggested.
No medication for mood.
Low dose quetiapine last 2 days.
Request 2nd opinion re outcome.

Diagnosis:	ICD10 Code:	

Follow Up

1	Client to seek follow up via GP	☐
2	Client to contact Care Team	☐
3	CPN will contact Care Team	☐
	Psychiatric medical opinion requested	☐
5	Admitted to hospital	☐
6	Urgent CMHT next day follow up	☐

Appropriate referral: **Yes** ☐ **No** ☐
(If No, explain):

Signature: _____

Care Plan

NHS
Greater Glasgow and Clyde

PIMS No/CHI No:	050282 3496 LABEL	Ward:	AMU
Name:	WESLEY PHILLIPS		
Address:	INVERCLYDE CENTRE		
Post Code:			
DoB & Gender:			

Need No. 1

Need
72 HR ASSESSMENT

Date	Intervention	Minumum Frequency of Intervention	Print & sign Name and Designation
	BUILD THERAPEUTIC WITH		
	WESLEY.		
	ENSURE OBS BASELINE OBS ARE		
	TAKEN BP, PULSE TEMP AND		
	BMI OBTAINED ON ADMISSION.		
	ENSURE ALL MEDICATION FROM		
	PRESCRIPTION SHEET ARE ADMINISTERED		
	OBSERVE WESLEY FOR ANY SIGNS		
	OF DETENTION IN MENTAL STATE		

Date	Intervention	Minumum Frequency of Intervention	Print & sign Name and Designation
	LIAISE WITH MEDICAL STAFF		
	RECORDING ANY CONCERNS ~~MADE~~		
	LIAISE WITH FAMILY		
	ORIENTATE PATIENT TO WARD		
	ENVIRONMENT,		

Patient/Carer's View/Understanding of Interventions

Staff Signature: _____ Date: _____

Patient/Carer Signature: _____ Date: _____

NHS Greater Glasgow & Clyde

Admission Form/SMR04 Data Form

Part 2 To be filed in patients Health Records

PATIENT DETAILS

CHI Number/DOB: 0 5 0 2 8 2 | 3 4 9 6 — Under 18 Y / N

PIMS Number (Glasgow only):

Surname: P H I L L I P S

Forename: W E S L E Y

Home Address: INVERCLYDE Centre — Home Tel:

Post Code: — Mobile Tel: 07466218880.

Sex: MALE (Male/Female) — Ethnic Group (Mandatory - See back for codes): 1A — Marital Status:

Next of Kin

Name: [redacted]

Address:

Post Code:

Home Tel:

Mobile Tel:

Relationship:

Is NOK to be:

Named Person or other Contact Details if Different from N.O.K.:

Is Contact to be Involved/Informed of Care? Y / N

GP Name/ Address

GP Name: DR. MCNEILL — Telephone Number: 501334

Address: CLYDESIDE PRACTICE

Admission/ Referral Details

See Back Cover for Codes

Date	Time of Arrival on ward (24 Hr)	Consultant	Ward	Admitted/Transferred From	Admission Reason
13/1/17	06:25am	DR ORR	LANGHILL AAU	A+E.	

Name of Admitting Hospital	Referred by:	Previous Psychiatric IP care: Yes / No If Yes Name of most recent Psychiatric Hospital	Admission Type
IRH	CRS		

Legal Status

FORMAL / INFORMAL
If **FORMAL** Section Detail: INFORMAL

Diagnosis

1. Diagnosis on Admission
2. Other Conditions

Discharge Details

See Back Cover for Codes

Date: 16/1/17 — Time (24hr): 16:30 — Discharge Type: 21 — Discharge to: INVERCLYDE CENTRE

Consultant on Discharge: Dr Orr — Ward on Discharge: AAU

Type of Psychiatric Care Provided: 1 — Aftercare Arrangements: B — Legal Status on Discharge: Informal

1. Discharge on Diagnosis
2. Other Conditions
3. Other Conditions

Care Programme Approach Y / N

Completed by _____ Signature _____

21:30 22:35

Out-of-Hours Psychiatric Nursing Service

NURSING ASSESSMENT

PATIENT DETAILS

Date 13/1/17
Name WESLEY PHILLIPS.
Address INVERCLYDE CENTRE.

Post Code

DOB

Tel No

PiMS No
GP Name
GP Address

Known to Service: YES ☐ NO ☐

If so, Consultant/Keyworker Name:

Time Triaged (24Hr)

HR	MIN

Referrer: A&E INVERCLYDE ROYAL
Assessor: D. RUSSELL / E URQUHART.

Time Visited

HR	MIN
03	00.

Time Assessment/Contact Completed

HR	MIN

Venue Patient See At:

Home ☐ A&E ☐ Hospital ☐
GEMS Clinic ☐ Police ☐
Other ☐ (Please specify):

HISTORY

1. Reason for Referral/History of Present Crisis:

BROUGHT TO A&E BY POLICE HAVING RAISED CONCERN BY PURCHASING 2 BOXES OF PARACETAMOL + BRUFEN, THEN ASKING OTHERS TO GET 8 MORE BOXES HAVING BEEN TOLD HE COULDN'T BUY THEM HIMSELF. REPORTS VOICE OF GOD TELLING HIM TO KILL HIMSELF

2. Relevant Psychiatric/Medical History/Present Medication:

KNOWN TO SERVICES PREVIOUSLY IN PAISLEY & APPEARS TO BE STILL OPEN ON PIMS TO ALCOHOL SERVICE.
HAS HAD ADDICTION ISSUES. DETOXED IN LONDON IN CHRISTIAN COMMUNITY.
→ COMMENCED ON SOMA QUETIAPINE
HAS PRESENTED FOR PSYCH ASSESSMENT ON SEVERAL OCCASSIONS SINCE NOVEMBER. NIL PSYCHOSIS EVIDENT ON EACH OCCASION

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☐
NURSING ☐

Please tick ✔ appropriate directorate

INESLEY PHILLIPS
0502823496

Date & Time		Signature, Print Name & Designation
	Mitchell GPST2 On Call Psych.	
13/1/17		
0530	34 ♂ Suicidal Ideation, hearing voices.	
	H.P.C - Brought into A+E by Police following paracetamol OD. Attempted to buy x10 packets of paracetamol at supermarket. Then asking people outside shop to buy Paracetamol for him. Seen on CCTV taking tablets. Assessed by A+E, paracetamol level < 5	
	Pt states does not wish to harm himself, but states has been hearing voices 'God' who is telling him to harm himself and take overdoses. States 'God does not want him here' feels he is not able to resist what the voices are saying. No usual hallucinations	
	- Describes recent low mood, associated with poor sleep and appetite. Concentration low.	
	- Took paracetamol OD 2/7's ago	
	- Assessed by Hassen psychiatry	
	- Seen multiple times recently by CRS	
	- Escalating behaviour. Feels he would harm himself again on d/c.	
	Past Psych Hx BPD, Low mood / Anxiety	
	Multiple OD in past ~20. last one ~1½ ago. Multiple previous IP admissions. All informal.	

Date & Time		Signature, Print Name & Designation
cont	PMHx Ex IVDU.	
	Prev methadone overuse	
	Hep C +ve.	
	SHx Lives in homeless hostel,	
	Little family support.	
	Numerous periods in prison in past,	
	↳ theft to fund drug habit	
	Drug + Alcohol Hx	
	18 year hx of heroin, cocaine, diazepam use	
	last took illicit drugs ~7 months ago.	
	Off methadone.	
	Prev methadone overuse.	
	Occasional alcohol intake.	
	Smoker ~x10/day	
	FHx [redacted]	
	Personal Hx - Born + raised in port Glasgow,	
	Moved South of England 2005.	
	Recently returned	
	Had been living in Christian rehab centre	
	x2 Brothers	
	Mother past away ~10 years ago.	
	MSE Good eye contact,	
	Affect appears reactive.	
	Dressed in lounge wear	
	Not obviously responding to any	
	visual or auditory hallucinations.	
	Insight appears good.	
	? Mild LD.	

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☐ NURSING ☐

Please tick ✔ appropriate directorate

WESLEY PHILLIPS
0502823496

Date & Time		Signature, Print Name & Designation
13/1/17 cont	O/E Alert, not obviously intoxicated	
	Chest → clear.	
	HS I + II + O	
	°Peripheral Oedema,	
	Abdo SNT, BS active	
	Grossly neurologically intact	
	Bloods unremarkable	
	ECG - S.R 76 bpm, NA acute, QTc 445,	
	IMP: Escalating behaviour within community,	
	ongoing suicidal thoughts. No safe	
	place for pt to be discharged to.	
	D/w Consultant On call Dr Rizob,	
	Who advise IP admission	
	Plan: 1) IP admission	
	2) Informal patient	
	3) General observations	
	4) Await consultant r/v.	
	5) pt aware no beds available	[signature]
	in AAU and may need	
	to source bed outwith IRH tomorrow.	

83949 GGC0072

NHS Greater Glasgow and Clyde

ADMISSION INFORMATION

PIMS NO/CHI NO:	0502823496	NAMED NURSE:	RUAN MCINTYRE Sam McCafferty
NAME:	Wesley Phillips	CONSULTANT:	Dr Orr
ADDRESS:	Inverclyde Centre	DATE/TIME ADMITTED:	13/1/17 0635am
POST CODE:		WARD	AAU LANGHILL
DOB & GENDER:	05/02/82 MALE		

ADMISSION DETAILS			
ADMITTED FROM:	A+E	ACCOMPANIED BY:	
SHO/REGISTRAR:		MHO	
ASSOCIATE NURSES [INCLUDING NIGHT STAFF]			
CARE MANAGER	Jaqui Haddock		
MENTAL HEALTH ACT/CRIMINAL PROCEDURES ACT STATUS ON ADMISSION		INFORMAL	
CARE PROGRAMME APPROACH STATUS ON ADMISSION EG. NOT ON CPA / ON CONTINUING CARE PROGRAMME / ON SEVERELY AT RISK PROGRAMME		NOT ON CPA	

CLINICAL OBSERVATIONS ON ADMISSION					
BLOOD PRESSURE:	124/75	PULSE	88.	TEMP	35.5.
ROUTINE URINE SPECIMEN	LIDS. NEGATIVE MACO URINALYSIS TRACE PROTEIN				
OXYGEN SATURATION	96%	RESPIRATORY RATE			

PHYSICAL DESCRIPTION					
HEIGHT:	6 FT 3 INS.	WEIGHT:	ST 13.5 KG LBS.	WALKING AID OR PROSTHESIS:	NO
COMPLEXION:	PALE			HAIR COLOUR/STYLE:	GREY/BLACK SHORT
EYE COLOUR:	BLUE			SPECTACLES/CONTACTS:	NO
DENTURES:	NO			BMI:	
HEARING AID:	NO			BUILD:	LARGE
DISTINGUISHING FEATURES: [TATTOOS, SCARS, BIRTHMARKS, PIERCINGS, ETC.] PLEASE DESCRIBE AND GIVE LOCATION				BATMAN TATTOO (L) ARM	
STAFF ALERTS E.G. HISTORY OF VIOLENCE/SELF HARM, HOME VISIT INSTRUCTIONS				PREVIOUS CONVICTIONS FOR VIOLENCE, PREVIOUS VIOLENT INCIDENTS	

NHS GREATER GLASGOW & CLYDE - MENTAL HEALTH CARE PLAN

NHS Greater Glasgow and Clyde

CHRONOLOGICAL ACCOUNT OF CARE

PIMS NO/CHI NO:	0502823496.	WARD:	AAU.
NAME:	Wesley Phillips.		
ADDRESS:	Inverclyde Centre.		
POST CODE:			
DOB & GENDER:	05/02/82 (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
13/1/17 15.30hrs	Occupational Therapy: Approached Wesley in his bedroom to explain the role of OT and make him aware of the groupwork activities on offer. Wesley expressed an interest in all the OT activities and reported that he would 'try' and attend the sessions planned for next week. He advised the writer he experiences auditory hallucinations, reporting that God is telling him to kill himself. Currently residing at the Inverclyde Centre – been there for three months. Previously attended a rehab centre in England, where he improved confidence/ skill engaging in various domestic ADLs.	A. BRAY. ABray (OT)
13/1/17 16.25	Medical Review – Dr Orr Note above. Reports that he has been formally DIC from rehab for 3/12. Was in rehab for 9/12 due to heroin use. Denies any relapse since DIC. Has been using alcohol but denies that this has been a recurrent problem. Prior to considering O/D before admission consumed "a bottle of something" & 2 cans of vodka & coke pre-mixed. States that his mood has been low	

CCP-CAC-220506

805751

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
	fam 2/52 c poor sleep & poor appetite.	
	Not distressed by living in Inverclyde	
	Centre.	
	Although complaining of 2/52 history	
	unable to account for contact c	
	MHS requesting input in latter part	
	of 2016.	
	Reports internal voice of God saying	
	- "Just Do It !" and believes	
	this is an order to kill himself -	
	"you can't disobey God". Despite	
	this he hasn't actually attempted	
	~~to~~ to seriously end his life.	
	Support fam his brother & friend so	
	not isolated.	
	MSE: Casually dressed. Spontaneous	
	speech c good eye contact and	
	receptive but flat affective. Mood	
	subjectively low at interview,	
	objectively depressed. Complaining of	
	internal hallucinations (auditory)	
	but unsure if these are his own	
	thoughts. Believes he needs	
	treatment c Chlorpromazine and	
	Procyclidine and to be in hospital.	
	Imp: Given past history and this	
	presentation I suspect more substance	
	misuse ~~that~~ than he is admitting to.	
	Also aspects of dissocial and	
	borderline personality traits/disorder	
	Plan: (1) observe over weekend c plan	
	for DC on Monday unless	

NHS GREATER GLASGOW & CLYDE - MENTAL HEALTH CARE PLAN

NHS Greater Glasgow and Clyde

CHRONOLOGICAL ACCOUNT OF CARE

PIMS No/CHI No:	0502823496	**WARD:**	AAU
NAME:	Wesley Phillips		
ADDRESS:	Inverclyde Centre		
POST CODE:			
DOB & GENDER:	05/2/82 ♂		

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
	13/1/17 contd...	
	evidence of mood/psychotic	
	disorder emerges.	
	② If any violence/aggression/	
	substance misuse to be D/C	
	immediately. Wesley aware of	
	this.	
	③ No change to medication -	
	due to E.D risk and this	
	being a period of assessment	[signature]
	I am not starting ~~information~~.	(ORR - CONS)
	any medication at this time	
13/1/17 20.30	NURSING: Wesley settled around ward this afternoon spending	[signature] [name] N/A
	more time in lounge area	
	enjoying the company of fellow	
	patients. Uncomplaining.	[signature] (S)
14/1/17 0000	NURSING: - WESLEY PLAYED CARDS WITH FELLOW PATIENTS BEFORE	K. MacGillivray
	RETIRING TO BED. SLEPT WELL OVERNIGHT. NO ISSUES	K. MACGILLIVRAY (S)
14/1/17	NURSING	WARD URINALYSIS - +++ PROTEIN	[signature]
	PLEASE OBTAIN MSSU ON MONDAY MORNING	[signature]
14/1/17	NURSING	Settled on ward spending majority	
	between lounge and room area. NO ISSUES	[signature]
		[signature] (S)

CCP-CAC-220506

D805751

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
14/1/17	Nursing Wesley has spent his evening	J. Mulgrew
20:05	in the lounge no complaints offered	J Mulgrew C
14-15/1/17	Nursing: Wesley Played Cards with	
0615 am	fellow Patients, No Interaction with staff,	
	Retured to bed, appeared to have slept	A McNeilage
	throughout the night.	Alli McNeilage Rm 5
12:30	NURSING Wesley has spent his morning	J. Mulgrew
	in his bed. No complaints offered	J Mulgrew C
15:00	NURSING: SPENT TIME BETWEEN	
	BEDROOM AND TV ROOM	
	PLAYING CARDS WITH FELLOW PATIENTS	RYAN MCINTOSH (S)
	APPEARED SETTLED ON WARD AND	
	WAS PLEASANT ON APPROACH.	Ryan McIntosh (S)
15/16/1/17 06:10. NIGHT	NURSING: SPENT A SETTLED EVENING AMONGST HIS PEERS	K. MacSatthews
	RETIRED TO BED AT MIDNIGHT AND HAS SLEPT SOUNDLY.	AIN
16/1/17	Occupational Therapy: Wesley declined invite to	
11.15hrs	attend relaxation, advised write he was waiting	A. BRAY
	to speak with the doctor.	A Bray (OT)
16/1/17	NURSING: Wesley remains Settled	G McCann
13:10.	around ward enjoying the	M Walker T/A
	Company of fellow patients	C Mowbray
	and Staff in lounge and	S
	No issues	Mc Mill
16/1/17	NURSING ~~We~~ A staff member from Inverclyde	
15:30	Centre called ward informing us that	
	Wesley was in his brother's house, ~~and~~	
	~~had said~~ They felt that until he had	
	been declared medically fit for discharge	
	they would be unable to allow him back	
	into Inverclyde Centre, Staff informed her	
	that Wesley had yet to be reviewed by	
	D. Or although the plan was to discharge	

NHS GREATER GLASGOW & CLYDE - MENTAL HEALTH CARE PLAN

NHS Greater Glasgow and Clyde

CHRONOLOGICAL ACCOUNT OF CARE

PIMS NO/CHI NO:	0502 82 5496	**WARD:**	AAU
NAME:	Wesley Phillips		
ADDRESS:	Inverclyde Centre		
POST CODE:			
DOB & GENDER:	05/2/82 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
contd,	him of this week, Staff called Wesley	
	and asked him to return to the ward,	
	until he was seen by Dr. Orr, Wesley said	
	that he wasn't coming back. Duty Dr Orr	S.Larkin
	informed of same.	Staff
16/1/17	Medical Entry - Dr Orr	
16.00	No concern noted by nursing staff regarding	
	mental state while on the ward - playing	
	cards, eating well.	
	Note above regarding refusal to return	
	to ward for review. Plan had been	
	to D/C today anyway as no evidence	
	of mental disorder => D/C in absence	
	c̄ no ψ F/U - any further review	[signature]
	by GP.	(ORR cons)
17/1/17	NURSING INVERCLYDE CENTRE HAS BEEN INFORMED	
	OF DISCHARGE. SEE NOTES ABOVE. NO MEDICATION	
	GIVEN TO.	

CCP-CAC-220506

D805751

Nutrition Profile

NHS Greater Glasgow and Clyde

Name: WESLEY PHILLIPS	Date of admission: 13 / 1 /17
Address: INVERCLYDE CENTRE	Time: 0625HRS
	HOSPITAL: IRH
DoB: 05/2/82	Ward: AAU
CHI number: 3U96.	
Affix patient data label	

To be recorded within 24 hours of admission*

Height: 6FT 3. metres Actual ☐ Patient/ carer reported ☐ Alternative measurement ☐

Weight: 137·5 kg Actual ☐ Patient/ carer reported ☐ Alternative measurement ☐

Recent unplanned weight loss: Yes ☐ No ☑

If 'Yes' how much?: kg Over what period of time?: weeks/months

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?:
GOOD APPETITE (NO ASKUS		

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): SLAPPER Signature: Slapper Date: 14/1/17

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

Is your patient on the Liverpool Care Pathway (LCP)? Yes ☐ No ☐

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

Malnutrition Universal Screening Tool ('MUST')												
Date	14/1											
Initials	S											
Height (see page 1) 6ft3 Weight	137.5											
Oedema or ascites present Y/N	N											
BMI (refer to chart on page 4)	30+											
'MUST'												
Step 1: BMI Score (refer to chart on page 4) >20 (>30 = Obese) .....0 18.5 - 20 .....1 <18.5.....2	0											
Step 2: Weight Loss Score Unplanned weight loss in past 3-6 months: <5% ..... 0 5-10% ..... 1 >10% 2	0											
Step 3: Acute Disease Effect Score If patient is acutely ill **and** there has been or is likely to be no, or virtually no, food intake for > 5 days..... Score 2 Not applicable ..... Score 0	0											
Step 4: Overall Risk of Malnutrition Total:												

Step 5: Management Guidelines

Score of Overall Risk of Malnutrition	Action Required
(0)	**LOW RISK – *Routine Clinical Care*** • Repeat screening. Hospital Acute .....Weekly Hospital Rehabilitation .....Monthly
1	**MEDIUM RISK – *Observe*** • 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 – *Treat**** • 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 asssistance 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

Date	Overall Risk	Action	Action discussed with patient / carer	Review date	Name (PRINT) Signature/ Designation
14/1.	O	ENCOURAGE HEALTHY DIET.			
		MONITOR WEIGHT WEEKLY		1/52	SUSAN S

NHS GREATER GLASGOW & CLYDE - MENTAL HEALTH CARE PLAN

TIME-OUT REVIEW RECORD

PIMS NO/CHI NO:	0502823406	**WARD:**	AMU
NAME:	Wesley Phillips		
ADDRESS:	c/o Inverclyde Centre		
POST CODE:			
DOB & GENDER:	5/2/82		

TIME OUT CODE	TIME LIMIT	SPECIFIC CONDITIONS TO TIME OUT (FREQUENCY/SPECIFIC RELATIVES ETC...)	NAME OFDOCTOR INVOLVED IN REVIEW	NURSE SIGNATURE
1	1.	UNDER PORTION OF ASSESSMENT, NO TIME		
		OFF WARD UNTIL DISCUSSED WITH		
		CONSULTANT.		SHARON Sloan

CODES:

ED (RMN):

3. ACCOMPANIED (2ND LEVEL REG NURSE OR NURSING ASST.):
4. ACCOMPANIED (INFORMED RELATIVE / AHP):
5. UNACCOMPANIED (GROUNDS O
6. FULL UNACCOMPANIED:

Safe & Supportive Enhanced Observation Review Record

Patient Name	Nesky Phillips	CHI No	05 0282 3490

anced rvation evel	Number of staff required	Specific Enhanced Observations Conditions: *Refer to conditions which apply as detailed in Care Plan & list relevant numbers at each review:* 1. *Verbal checks & prompts when patient is in toilet/shower/bathroom* 2. *Observation in a communal area by a designated person* 3. *Forward plan which indicates when observation level can be lowered* 4. *Appropriate relative involved in Constant Observation on and / or off ward* 5. ***When RMO only can lower level***	Reviewi Docto
IPLE TANT	**EXAMPLE** 1	**EXAMPLE** 1, 2, 3, 4 (ON & OFF WARD)	**EXAMPL** DR A SMIT
		HOURLY CHECKS TO BE CARRIED OUT, STAFF TO BE AWARE OF WHEREABOUTS	

Short Stay Psychiatric Unit IRH

PATIENTS BELONGINGS AND VALUABLES

NAME: W. PHILLIPS WARD: AAU DATE: 13/1/17

Inform Nurse in charge if any patients (informal or under Section) is unable to make a decision or refusing admitting nurse to check their belongings.
Nurse in charge will discuss with medical staff and record in nursing notes.

CLOTHING CHECKED YES/NO	VALUABLES / JEWELLERY
	GLASSES ~~YES~~/NO
	DENTURE ~~YES~~/NO
	~~FULL/PARTIAL~~
	HEARING AID ~~YES~~/NO
	~~PROSTHESIS~~
	1X NOKIA MOBILE PHONE
	£170 CASH
	1X WRIST WATCH
	BUS PASS
	P.O. CARD

SIGN: OF PATIENT W. Phillips DATE: 13/1/17
SIGN: OF NURSE Thomas McGeown DATE: 13/1/17
SIGN: OF SECOND NURSE [illegible] DATE: 13/1/17

The above item(s) has/have been kept by the patient who is accepting [illegible] be made to the Trust against loss

lth Services

Prescription Sheet No. 1

LIPS	CHI (10 digits) 050 2523496	WARD/HOSPITAL AAU	CONSULTANT GKR	DAT

REGULAR PRESCRIPTIONS

MEDICINE (Block letters) - APPROVED NAME	DOSE	ROUTE	TIMES (24 hour) 0900	1300	1700	2200	OTHER TIMES			PRESCRIBER SIGNATUR
QUETIAPINE	25 MG	PO	✓			✓				
ZOPICLONE (Not for long term)	7.5 MG	PO				✓				

AS REQUIRED PRESCRIPTIONS	DOSE	ROUTE	INDICATION	DOSE INTERVAL	MAX DOSE IN 24HRS	
SYMPTOMATIC RELIEF POLICY	AS PER PROTOCOL					

DEPOTS/LONG-ACTING INJECTIONS	DOSE	FREQUENCY

ONCE ONLY MEDICATIONS	DOSE	ROUTE	TIME	SIGNATURE	GIVEN BY	TIME GIVEN	A

APPROPRIATE ALERT STICKERS

T2/T3	RISK OF INFECTION	KNOWN ALLERGY/ADVERSE DRUG REACTION - DETAILS
		NKDA.

alth Services

Recording Sheet No.______

PRESCRIPTIONS TIMES (24 hour) 1300	1700	2200	OTHER TIMES			AS REQUIRED			DEPOT	CON DISC
		A B km								
		A B km								
		A B RJ								

HILLIPS	CHI (10 digits) 0502823496	WARD/HOSPITAL	CONSULTANT OMM	Circle letter eg. (A) if medicine not given Document reason in comments/discrepancie