A&E Records

Directorate of
Accident and Emergency Medicine
LOTHIAN UNIVERSITY HOSPITALS NHS TRUST

THE ROYAL INFIRMARY OF EDINBURGH
51 Little France Crescent
Edinburgh EH16 4SU
Telephone:0131 242 1300
Fax: 0131 242 1344

NHS
Lothian

A/E no. E1574630
E586944
Previous no.

UHPI no. 700070925K
CHI no. 0409781118

PATIENT INFORMATION

Surname Spiers
Forename George
Date of Birth 04/09/1978
Age 31 Yrs Sex M

Address 126 Gilmerton Dykes Road
Edinburgh
Midlothian
Postcode EH17 8PE
Telephone 6643978

Contact Cherry, Ann
Address
Telephone H 01501 733 935
W

Complaint wound to chin
Allergies

Attendances in last 12 months: 0 School:

General Practitioner

Name
LE Duncan
Address
24 Gracemount Drive
Edinburgh
EH16 6RN
Telephone 0131 664 2377

Date and Time of Attendance
03/10/2009 02:13
Incident Date & Time: 03/10/2009 01:00
Mode of Arrival
Emergency Ambulance
Source of Referral
999 Emergency

T	P	RR	BP	BM	SpO2	Peakflow	Urinalysis	Alcometer

Nursing Assessment Alleged assault lac to chin requires dsg, states ? knife, also c/o paying thumb.

Pain Assessment Score
Waterlow Score
Pain Score Review
Time
Triage Score
Signature [signature]
Time
Print Name LKO

Clinical Notes

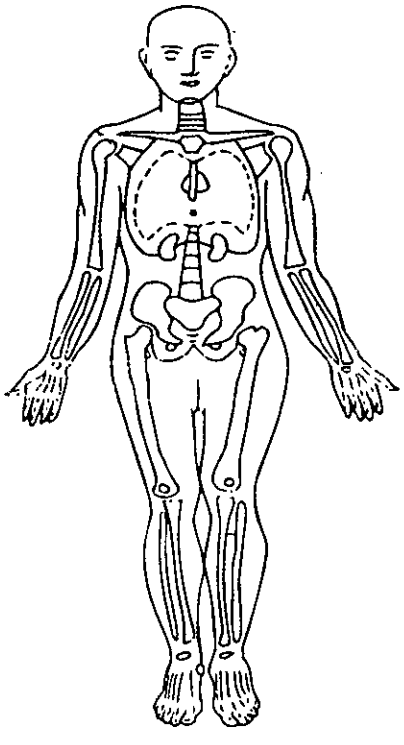
(81) PC: alleged assault
slash to (L) jaw 3 cm long to
s/c tissues
° other assault.
ē PMH / DH.

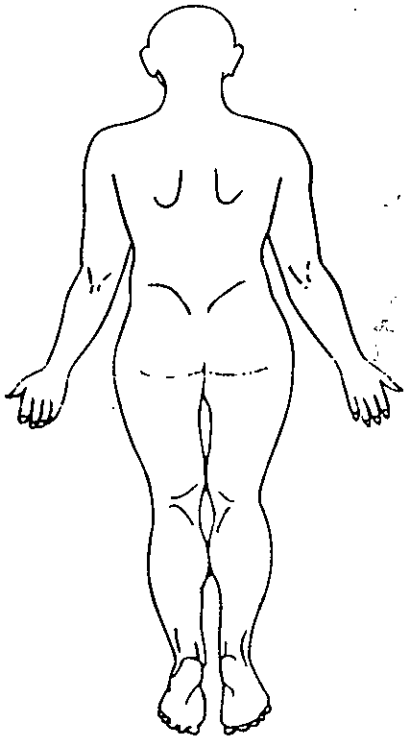
Plan: clean & injected 0.1% ...
Inf 2% lidocaine
4 x c.ethilon stitches
out in 7/7 ē GP
tetanus up to date
incident reported to police.

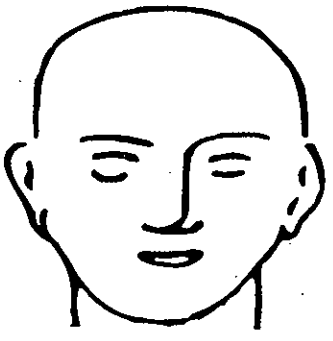
Diagnosis

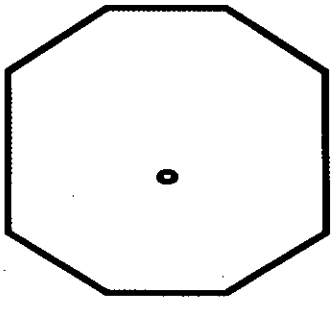
Doctor's Name (print) MATT ...
Signature [signature]

Nursing Release				Clinical Notes Continued
Instruction/Health Education	Y	N	N/A	
Medication	Y	N	N/A	
Review				
X-rays	Y	N	N/A	
Clinic	Y	N	N/A	
Notes/X-rays	Y	N	N/A	
Walking Aids	Y	N	N/A	
Transport				
Self	Y	N	N/A	
Other	Y	N	N/A	
Amb ref no.....	Y	N	N/A	
Primary Care Ref.				
Safe Home	Y	N	N/A	
Crisis Care	Y	N	N/A	
District Nurse	Y	N	N/A	
GP	Y	N	N/A	
NoK/carer aware				
Documentation Complete	Y	N		
CSW signature				
RN signature				

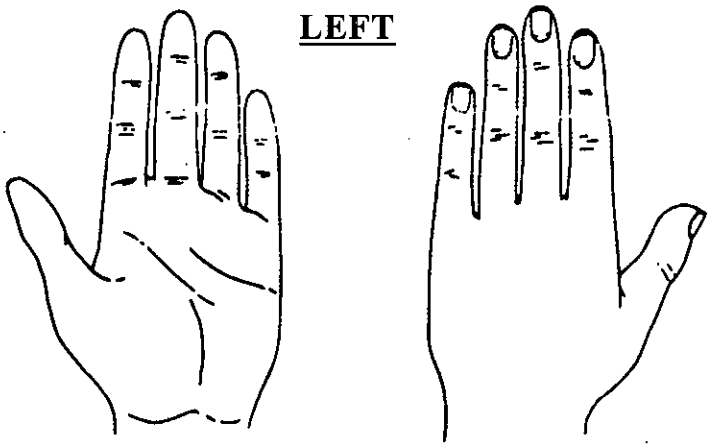




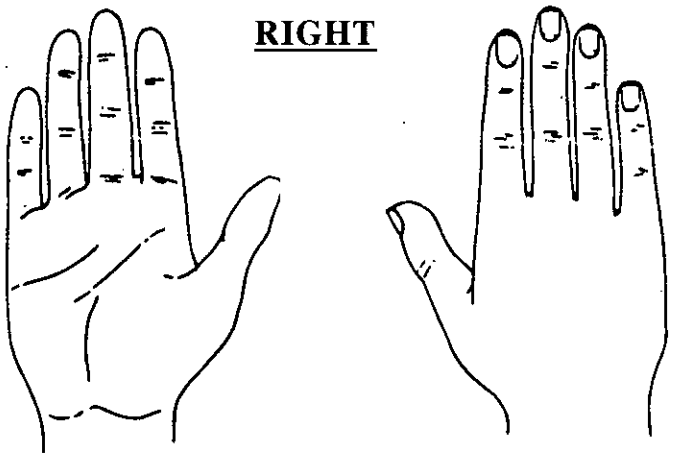




LEFT



RIGHT



ROYAL INFIRMARY OF EDINBURGH
EMERGENCY DEPARTMENT

700070925K/E1638027 M 04/09/1978
Spiers, George
126 Gilmerton Dykes Road,
Edinburgh,
Midlothian,
EH17 8PE
CHI
70319 DG Pope

ALLERGIES	NKDA.

DRUG AND PRESCRIPTION RECORD
ONCE ONLY PRESCRIPTION

Date 9/1/10

Date	Time	Drug (Approved Name)	Dose	Route	Prescriber's Signature	Time Given	Given By (Initials)	Checked By (Initials)
9/1/10	0400	PARACETAMOL	1g	PO	MD.	0410	MD	

Insulin Sliding Scale Prescription Chart

BM	Insulin u/hr	Dextrose 10% ml/hr	Other Action	BM	Insulin u/hr	Dextrose 10% ml/hr	Other Action
				INSULIN		SIGNATURE	

STOP

CHECK: Does this patient have a Drug Kardex?
If YES, discontinue this prescription record

DRUG INFUSION	DRUG NAME	STARTING AMOUNT	TIME / MLS	TIME / MLS	TIME / MLS	TIME / MLS	TIME / MLS	TIME / MLS	TIME / MLS	TIME / MLS	TIME / MLS	TIME / MLS

Directorate of
Accident and Emergency Medicine
LOTHIAN UNIVERSITY HOSPITALS NHS TRUST

CH

THE ROYAL INFIRMARY OF EDINBURGH
51 Little France Crescent
Edinburgh EH16 4SU
Telephone:0131 242 1300
Fax: 0131 242 1344

NHS Lothian

A/E no. E1638027
Previous no. E1574630
UHPI no. 700070925K
CHI no. 0409781118

PATIENT INFORMATION

Surname Spiers
Forename George
Address 126 Gilmerton Dykes Road
Edinburgh
Midlothian
Postcode EH17 8PE

Date of Birth 04/09/1978
Age Yrs Sex M
Telephone 0643978

Contact Address Cherry, Ann
Telephone 01501 733 935
W

Complaint facial inj

Allergies trust 1 v/c Police

Attendances in last 12 months: 1 School:

General Practitioner

Name
DG Pope
Address
West End Medical Practice
2 Chester Street
EH3 7RF

Telephone 0131 225 5220

Date and Time of Attendance
09/01/2010 03:21
Incident Date & Time: 09/01/2010 01:00
Mode of Arrival
Police
Source of Referral
Police

T	P	RR	BP	BM	SpO2	Peakflow	Urinalysis	Alcometer

Nursing Assessment alldgd assault facial inj no hoc GCS 15.

Pain Assessment Score | Waterlow Score

Pain Score Review | Time | Triage Score

Signature Sutton. | Time | Print Name

Clinical Notes

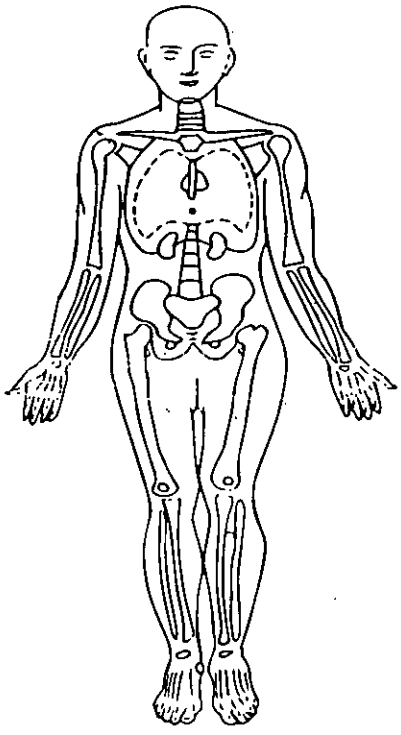
Alleged assault this am.

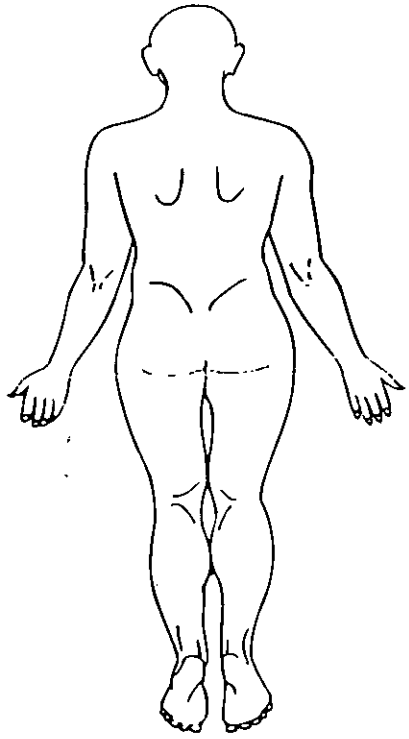
Marked (L) haematoma inferior to (L) eye + swelling & bruising +++.

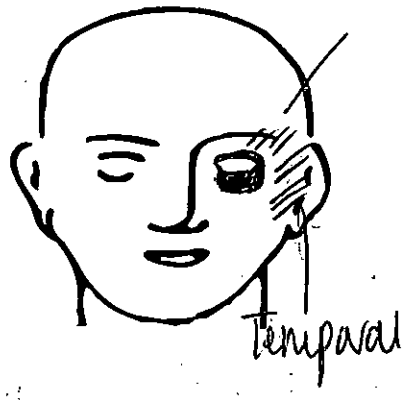
Diagnosis

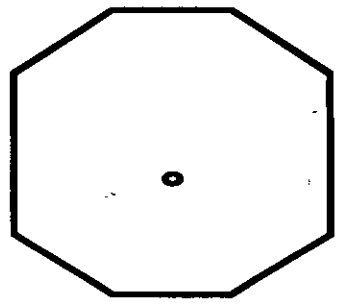
Doctor's Name (print) | Signature

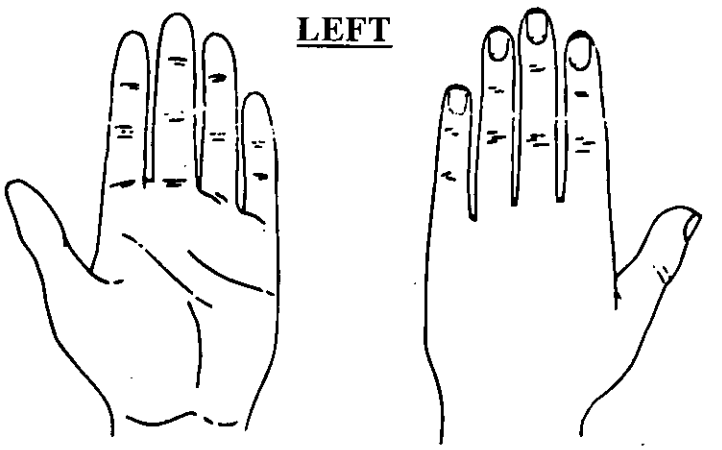
Nursing Release				Clinical Notes Continued
Instruction/Health Education	Y	N	N/A	
Medication	Y	N	N/A	
Review				
X-rays	Y	N	N/A	
Clinic	Y	N	N/A	
Notes/X-rays	Y	N	N/A	
Walking Aids	Y	N	N/A	
Transport				
Self	Y	N	N/A	
Other	Y	N	N/A	
Amb ref no.....	Y	N	N/A	
Primary Care Ref.				
Safe Home	Y	N	N/A	
Crisis Care	Y	N	N/A	
District Nurse	Y	N	N/A	
GP	Y	N	N/A	
NoK/carer aware				
Documentation Complete	Y	N		
CSW signature				
RN signature				











THE ROYAL INFIRMARY OF EDINBURGH

SELF DISCHARGE FORM

Pat 500807310M/E2035715 M 04/09/1978
Spiers, George
33/3 Wester Hailes Park,
Edinburgh,
Nam EH14 3AG
CHI 0409781118
Affb 77106 PM Bailey

PART A

This is to certify that I am discharging myself/my child* today at my own risk and against medical advice.

Date: 27/8/11 Time: 1025

The possible consequences of discharging myself/my child* have been fully and clearly explained to me by Dr/Mr. DAVIDSON and I take full responsibility for my actions.

Patient or Guardians Signature: George Spiers Date: 27.8.11

Doctors Signature: Date: 27/8/11

Doctors name and designation: DAVIDSON

Witness Signature: PC 116/6 ST LEONARDS Date:

Witness name and designation: J. FERGUSON PC 116/6 STH LEONARDS

PART B

Patient refused to sign self discharge form and/or would not wait to speak to medical staff.

Signed: Date:

Name & Designation:

*Delete as appropriate

Notes to staff.

1. Please ensure this form is fully completed and that all parties have signed in part A.
2. Ensure all entries are legible.
3. The form should be filed immediately in the correspondence section of the patient's record.
4. If the patient refuses to complete this form or leaves the hospital before it is completed, part B should be completed, the form filed as above and a full report entered in the patient's record.

Directorate of
Accident and Emergency Medicine
LOTHIAN UNIVERSITY HOSPITALS NHS TRUST

Clinical Lead Dr. A. Gray
Clinical Nurse Manager Mr. Neil Boyle

THE ROYAL INFIRMARY OF EDINBURGH
51 Little France Crescent, Edinburgh EH16 4SU
Tel: 0131 242 1300 • Fax: 0131 242 1344

NHS Lothian

A/E no E2035715

Previous no. E1638027

UHPI no 500807310M

CHI no. 0409781118

PATIENT INFORMATION

Surname Speirs
Forename George
Date of Birth 04/09/1978
Age 32 Yrs Sex M

Address 33/3 Wester Hailes Park
Edinburgh

Postcode EH14 3AG
Telephone 07722 250 045

Contact Address Cherry, Ann
Telephone H 01501 733 935
W

Complaint head injuries
Allergies

Attendances in last 12 months: 0
School:

General Practitioner

Name
PM Bailey
Address
Newbattle Medical Practice
Blackcot
Mi EH22 4AA

Telephone 0131 663 1051

Date and Time of Attendance
26/08/2011 23:28
Incident Date & Time: 26/08/2011 21:30
Mode of Arrival
Emergency Ambulance
Source of Referral
999 Emergency

T	P	RR	BP	BM	SpO2	Peakflow	Urinalysis	Alcometer
37.2	94	16	133/56		98% r/a			

Nursing Assessment Pt states he fell down stairs. Pt refuses to give any details ?LOC. GCS 15 PEARL (3)

(P) A+E docs

Pain Assessment Score
Waterlow Score

Pain Score Review
Time
Triage Score

Signature [signature]
Time 2340
Print Name [signature]

Clinical Notes

32 yo ♂

Assault alleged. 3 people vs pt.
Refusing to give details.
Denies any injuries except to face.
Possible LOC.
Now feels well

o/E

Haematomas as noted overleaf -
Small wounds as noted overleaf. R supra-orbital wound 1x suture

Wounds cleaned
Occiput wound - 1x staple

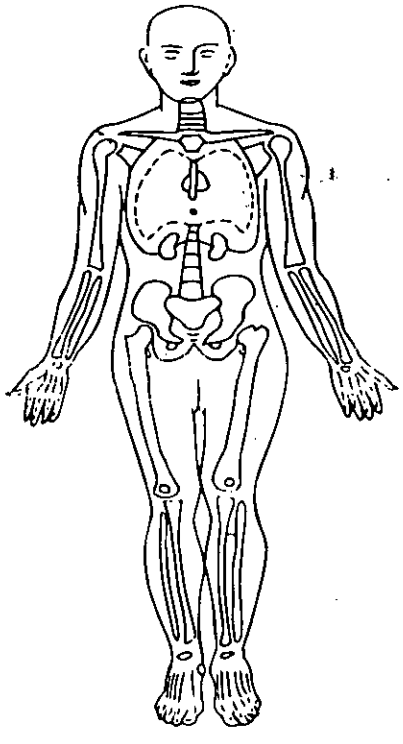
Diagnosis

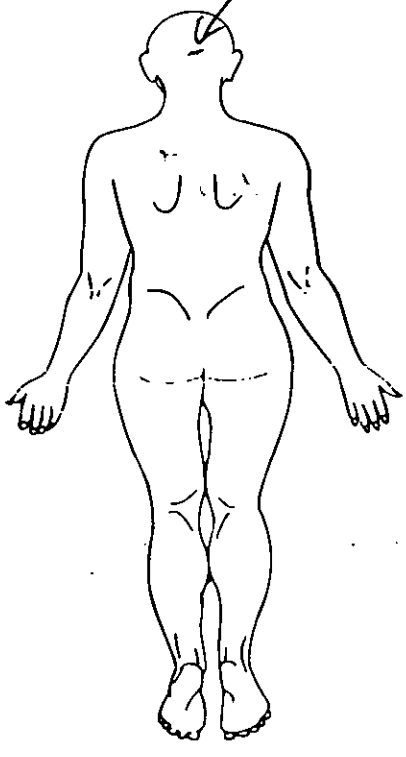
Doctor's Name (print) [illegible]
Signature [signature]

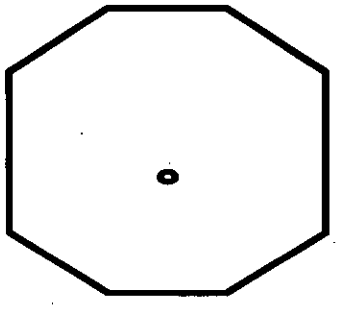
Nursing Release				Clinical Notes Continued
Instruction/Health Education	Y	N	N/A	
Medication	Y	N	N/A	Explained ideally would want to discharge - now c 3 hours post injury
Review				
X-rays	Y	N	N/A	
Clinic	Y	N	N/A	Woman pt left Dorset.
Notes/X-rays	Y	N	N/A	
Walking Aids	Y	N	N/A	Given verbal advice
Transport				
Self	Y	N	N/A	
Other	Y	N	N/A	RCS 1/52
Amb ref no.....	Y	N	N/A	
Primary Care Ref.				
Safe Home	Y	N	N/A	
Crisis Care	Y	N	N/A	
District Nurse	Y	N	N/A	
GP	Y	N	N/A	
NoK/carer aware				
Documentation Complete	Y	N		
CSW signature				
RN signature				

Staple

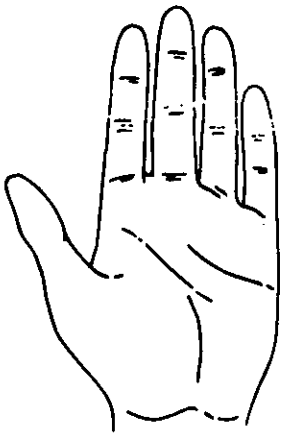
Suture 5-0

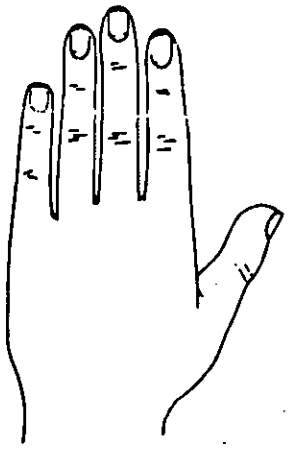




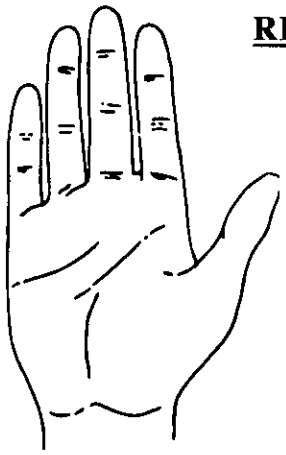


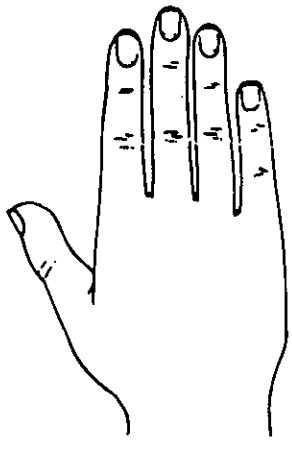
LEFT





RIGHT





NHS Lothian

Royal Infirmary of Edinburgh
51 Little France Crescent
Old Dalkeith Road
Edinburgh EH16 4SA

Dr PM Bailey
Newbattle Medical Practice
Blackcot
Mayfield
Midlothian
EH22 4AA

Date: 02/09/2011

Emergency Discharge Summary

Patient	George Speirs 33/3 Wester Hailes Park Edinburgh EH14 3AG	**CHI**	**0409781118**
		Date of Birth / Age	04/09/1978 (32 years)
		UHPI	500807310M
		A&E Attendance Number	E2035715
Attendance Date	26/08/2011	**Contact**	Cherry Ann 01501 733 935
Attendance Time	23:28		
Mode of Arrival	Emergency Ambulance		
Source of Referral	999 Emergency		
Discharge Date	27/08/2011		
Discharge To			

Dear Dr PM Bailey

Presentation: head injuries

CHI: 0409781118

32 yo male, alleged assault 3 people vs pt. Pt refusing to give details. Denies any injuries except to face. Possible LOC. Now feels well.

OE: Haematomas to left forehead, centre forehead, left and right supraorbital ridges, right cheek and right jaw with associated skin wounds to right middle forehead, right supraorbital ridge and right suprauricular region. One wound to occiput also.

Pt refusing to stay in hospital and has self discharged but allowed me to close his occiput wound with a staple and the right supraorbital ridge wound with 1 x 5/0 interupted suture.

Any queries please contact A&E Reception on 0131 242 1300

Yours Sincerely,

Dr Craig Davidson, Doctor

NHS Lothian
University Hospital Services
Department of Emergency Medicine

Clinical Director Dr. D.Caesar
Clinical Nurse Manager Mrs. Karen McFarlane
ST. JOHN'S HOSPITAL
Howden Road West, Livingston EH54 6PP
Tel: 01506 523000

NHS Lothian

LOT 163

A/E no. E3285056 DGP
Previous no. E2035715
UHPI no.
CHI no. 500807310M
CHI no. 0409781118

PATIENT INFORMATION

Surname: Speirs
Forenames: George
Date of Birth: 04/09/1978
Age: 37 yrs
Sex: M
Address: 26 Torwoodlee Road, Galashiels, Selkirkshire
Postcode: TD1 1RP
Telephone: 07951350383
Contact Address: Cherry, Ann
Telephone: 01501 733 935 W
Complaint: upper lip lac
Allergies: nil
Attendances in last 12 months: 0
School:

General Practitioner

G Sim
Address
The Ellwyn Practice
The Health Centre
TD1 2UA
Telephone 01896 661355

Date and Time of Attendance
31/05/2016 18:25
Incident Date & Time: 29/05/2016 18:00
Mode of Arrival
Private Transport
Source of Referral
Self Referral to A&E

Temp	Pulse Rate	BP	RR	Sats O_2/air	BM	PF best	Alcometer	GCS	SEWS
36.7	62	127/92	16	99 % RA				/15 e__v__m__	

Presenting Complaint: cut to inside of upper lip. hit on lip.
History of Presenting Complaint: yellow exudate from wound 2/7.
Assessment:

Triaged no.: 1 2 3 (4) 7 *(circle)* Senior Doctor Informed? Y / N time.....

BLOODS Routine ☐ Troponin ☐ Amylase ☐ TOX ☐ Other ☐ _____ Bloods Done ☐ _____
time due..... (time of OD.....)
PVC Started (time) .....

ECG Required ☐ Done ☐ Time.....

X-RAYS CXR ☐ Other ☐ _____

URINALYSIS Required ☐ Done ☐ HCG: + / – *(circle)* MSU Sent: Y / N nil meds

PAIN SCORE ___/10 Analgesia ☐ Time.....

Peripheral Venous Cannula Insertion *Complete all sections*
Date:..... Time:..... Operator:.....

Size		Position		Standard technique	
Blue	☐	LEFT	☐	Handwash	☐
Pink	☐	RIGHT	☐	Gloves	☐
Green	☐	Hand	☐	CHD skin prep	☐
Orange	☐	Forearm	☐	Aseptic insertion	☐
Brown	☐	ACF	☐	Needle free port	☐
Grey	☐	Foot	☐	Dressing labelled	☐

Difficulties/complications/deviation from standard technique-
Operator Signature:.....

Are any 2 of the following present:

1. temp >383 or <36 ☐
2. HR > 90 ☐
3. RR > 20 ☐
4. WCC > 12 or < 4 ☐
5. BM > 7 (+ not diabetic) ☐
6. age > 70 ☐
7. signs of infection ☐

>2 → think sepsis and triage up start Sepsis 6

FAST + / – *(circle)* Onset Time: .....
Stroke Test
Speciality Informed ☐ time ..... Speciality:.....

Time of Triage: 2020
Triaged by: *(sign)* .....
(print) .....
Clinician: *(sign)* .....
(print) M.....

Hit 1/L object ? what ~~[illegible]~~ 48hrs ago (Sunday) :
fell hitting (R) side head °LOC
°dizzy / lighthead felt nausea at time of
injury - resolved since.

Seen by SRS @ time - declined to attend.

1800 Sun evening

T36.7 P67 Bp $^{129}/_{84}$ O_2 Sats 99% RA —

GCS $^{15}/_{15}$ PERL (4). =m power x 4 limbs

(R) pinna bruised.
centre upper vade lip - sloughy. vermilion ~~borders~~ border cross.

Care Providers Name:.. Signature:..

LHB 925

NHS Lothian
University Hospital Services
Department of Emergency Medicine

Clinical Director Dr. O.Caesar
Clinical Nurse Manager Mr. Chris Connolly
THE ROYAL INFIRMARY OF EDINBURGH
51 Little France Crescent, Edinburgh EH16 4SA
Tel: 0131 242 1300 • Fax: 0131 242 1344

NHS Lothian

A/E no. E3325879
Previous no. E3285056
UHPI no. 500807310M
CHI no. 0409781118

PATIENT INFORMATION

Surname Speirs
Forenames George
Date of Birth 04/09/1978
Age 37 Yrs Sex M

Address 26 TORWOODLEE ROAD
Galashiels
Selkirkshire
Postcode TD1 1RP
Telephone 07484708789

Contact Address Cherry, Ann
Telephone 01501 733 935
W

Complaint lip lac
Allergies

Attendances in last 12 months: 1
School:

General Practitioner

G Sim
Address
The Ellwyn Practice
The Health Centre
TD1 2UA
Telephone 01896 661355

Date and Time of Attendance
23/07/2016 17:34
Incident Date & Time:
Mode of Arrival
Private Transport
Source of Referral
Self Referral to A&E

TRIAGE

Presenting Complaint: bit by own dog x 2 deep lacs to
History of Presenting Complaint: to chin ? radiating to lower lip
Assessment: ATTS ? ab schd

OBSERVATIONS

Temp	Pulse Rate	BP	RR	Sats %	O2/air	BM	PF best	Alcometer	GCS	SEWS
		/							/15 e__v__m__	

? SEPSIS temp >383 or <36 ☐ HR > 90 ☐ RR > 20 ☐ BM > 7 (+ not diabetic) ☐ age > 70 ☐ signs of infection ☐

> 2 **THINK SEPSIS AND TRIAGE UP** Y / N

PAIN SCORE ____/10 Analgesia ☐ Time ________
FAST + / - *(circle)* Onset Time: ________
Stroke Test

Triaged no.: 1 2 3 4 7 *(circle)* Triaged to: HD / IC / exam / WR / GP *(circle)* Senior Doctor Informed? Y / N time________

INTERVENTIONS & INVESTIGATIONS

Peripheral Venous Cannula Insertion *Complete all sections*
Date: .... Time:..............

Size		Position		Standard technique	
Blue	☐	LEFT	☐	Handwash	☐
Pink	☐	RIGHT	☐	Gloves	☐
Green	☐	Hand	☐	CHD skin prep	☐
Orange	☐	Forearm	☐	Aseptic Insertion	☐
Brown	☐	ACF	☐	Needle free port	☐
Grey	☐	Foot	☐	Dressing labelled	☐

Operator Signature: ....

BLOODS Routine ☐ Troponin ☐ Amylase ☐
(Trop due________)
TOX ☐ Other ☐ ________
(time of OD________)
BTS ☐ SENT ☐

ECG Required ☐ Done ☐ Time________ **X-RAYS** CXR ☐ Other ☐ ________

URINALYSIS Required ☐ Done ☐ HCG: + / - *(circle)* MSU Sent: Y / N

BED REQUIRED YES / NO *(circle)*

Time of Triage: 1840

Speciality Informed ☐ Time________

Triaged by: *(sign)* [signature]
(print) [handwritten name]

Care Provider: *(print)* ....

"WHAT MATTERS TO THE PATIENT?"

THINK:- OTHER SOURCES OF INFORMATION:

FAMILY ☐ CARERS ☐ SAS PRF ☐ EPR ☐ ECS ☐ KIS ☐ GP ☐ PATIENT ALERTS ☐

Care Providers Name:..... Signature:.....

NHS Lothian

Royal Infirmary of Edinburgh
51 Little France Crescent
Old Dalkeith Road
Edinburgh EH16 4SA

Dr G Sim
The Ellwyn Practice
The Health Centre
Currie Road
Galashiels
TD1 2UA

Date: 24/07/2016

Emergency Discharge Summary

Patient	George Speirs 26 TORWOODLEE ROAD Galashiels Selkirkshire TD1 1RP	**CHI**	**0409781118**
		Date of Birth / Age	04/09/1978 (37 years)
		UHPI	500807310M
		A&E Attendance Number	E3325879
Attendance Date	23/07/2016	**Contact**	Cherry Ann 01501 733 935
Attendance Time	17:34		
Mode of Arrival	Private Transport		
Source of Referral	Self Referral to A&E		
Discharge Date	23/07/2016		
Discharge To			

Dear Dr G Sim

Presentation: lip lac

CHI : 0409781118

37 year old male.

PMH - Nil. Meds - Nil. NKDA.

PC - dog bite to lower lip. Pt reports that he was bitten by his own rottweiller this evening.

O/E - Looks well. 2 x oblique wounds to lower lip which both cross the vermillion border. Wound to central lower lip measures approx 2cm x 1cm. WOund to right side of lower lip measures approx 1cm x 0.2cm. Wounds not activelty bleeding. No FB observed in wounds. NO intraoral wounds or swelling.

IMP - Dog bite lower lip.

D/W Plastics.

PLAN - Thorough wound lavage. CO-amoxicalv 625mg PO TDS. TO attend ward 18, SJH, 0830hrs next day. Advised fast from midninght.

Leon Amos
Nurse Practitioner

Yours Sincerely,

Leon Amos, Nurse

Patient & GP Information

UHPI Number	500807310M
CHI Number	0409781118
Episode Number	04110376
Surname/Forename	Speirs, George
Date of Birth	04/09/1978
Sex	Male
Patient Address.	"20 Newbattle road, " Newtongrange, .Dalkeith EH22 4RL
Registered GP	G Sim
GP Address.	The Ellwyn Practice,The Health Centre,Currie Road,Galashiels TD1 2UA

Report Contents

The report bundle provides information on the following:

* IP/OP Clinical Notes

Patient & GP Information

500807310M	500807310M
0409781118	0409781118
E046060	E1574630
Speirs, George	Speirs, George
04/09/1978	04/09/1978
Male	Male
"20 Newbattle road, " Newtongrange, .Dalkeith EH22 4RL	"20 Newbattle road, " Newtongrange, .Dalkeith EH22 4RL
G Sim	G Sim
The Ellwyn Practice,The Health Centre,Currie Road,Galashiels TD1 2UA	The Ellwyn Practice,The Health Centre,Currie Road,Galashiels TD1 2UA

Patient & GP Information

500807310M	500807310M
0409781118	0409781118
E1638027	E2035715
Speirs, George	Speirs, George
04/09/1978	04/09/1978
Male	Male
"20 Newbattle road, " Newtongrange, .Dalkeith EH22 4RL	"20 Newbattle road, " Newtongrange, .Dalkeith EH22 4RL
G Sim	G Sim
The Ellwyn Practice,The Health Centre,Currie Road,Galashiels TD1 2UA	The Ellwyn Practice,The Health Centre,Currie Road,Galashiels TD1 2UA

Patient & GP Information

500807310M	500807310M
0409781118	0409781118
E3285056	E3325879
Speirs, George	Speirs, George
04/09/1978	04/09/1978
Male	Male
"20 Newbattle road, " Newtongrange, .Dalkeith EH22 4RL	"20 Newbattle road, " Newtongrange, .Dalkeith EH22 4RL
G Sim	G Sim
The Ellwyn Practice,The Health Centre,Currie Road,Galashiels TD1 2UA	The Ellwyn Practice,The Health Centre,Currie Road,Galashiels TD1 2UA

Patient & GP Information

500807310M	500807310M
0409781118	0409781118
E534930	E586944
Speirs, George	Speirs, George
04/09/1978	04/09/1978
Male	Male
"20 Newbattle road, " Newtongrange, .Dalkeith EH22 4RL	"20 Newbattle road, " Newtongrange, .Dalkeith EH22 4RL
G Sim	G Sim
The Ellwyn Practice,The Health Centre,Currie Road,Galashiels TD1 2UA	The Ellwyn Practice,The Health Centre,Currie Road,Galashiels TD1 2UA

Patient & GP Information

500807310M
0409781118
E815602
Speirs, George
04/09/1978
Male
"20 Newbattle road, " Newtongrange, .Dalkeith EH22 4RL
G Sim
The Ellwyn Practice,The Health Centre,Currie Road,Galashiels TD1 2UA

Surname/Forename	Speirs, George
UHPI Number	500807310M

Episode Number	04110376

Inpatient/Outpatient Clinical Notes

Note Details	Clinical Notes
Historic SJH A&E Conversion Data Episode/Ref: E815602 Dr P Freeland 29/02/2008 17:45	A&E Doctor 1: DR R STEWART,Time Seen: 02:50,Alcohol: 1,Provisonal Diagnosis: 16DA,Drug 1: Nil ,Investigation 1: Nil ,Destination: ,Examination: ASSAULT,Primary Diagnosis: ASSAULT + LACN.

Surname/Forename	Speirs, George
UHPI Number	500807310M

Episode Number	04110376

Note Details	Clinical Notes
A&E Notes Episode/Ref: E1574630 Dr Matt Pitts 20/11/2009 18:31 Lauren Lynch	31 yr old male allegedly assaulted, slashed to L jaw. Approx 3cm long into subcutaneous tissues, no other injuries. ,,PMH/DH - Nil. NKDA. ,,Cleaned and irrigated with normal saline under LA. 4 x 6/0 Ethilon used to close. GP ROS 7 days. ATTB covered. Incident reported to police. ,,LL

Surname/Forename	Speirs, George
UHPI Number	500807310M

Episode Number	04110376

Note Details	Clinical Notes
A&E Notes Episode/Ref: E1638027 Dr Mathew Davies 09/01/2010 04:39 Mathew Davies	Pt No : 700070925K,,31 yr old male presenting following alleged assault this am.,,GCS 15/15 on admission. Denies LOC.,,Marked L Haematoma inferior to L eye identified. Periorbital swelling + +,,Currently Orientated to Time, Place and Person.,,O/E : Settled.,,C/O L Temporal tenderness.,,GCS 15/15.,PEARL and Full range of eye movements. No Nystagmus or double vision.,CN II-XII intact. Facial movements / sensation intact.,No focal neuro identified.,Mild periorbital tenderness only.,,Tympanic membranes intact.,No Mandibular tenderness identified,,XR Skull - No # identified.,,IMP : Mechanical facial injury secondary to alleged assault. No ongoing concerns.,,PLAN : Analgaesia prescribed.,D/C back into police custody with Head Injury advice.,,Advised to return if any ongoing concerns.

Surname/Forename	Speirs, George
UHPI Number	500807310M

Episode Number	04110376

Note Details	Clinical Notes
A&E Notes Episode/Ref: E2035715 Dr Craig Davidson 02/09/2011 17:48 Sara Osburn	CHI: 0409781118,,32 yo male, alleged assault 3 people vs pt. Pt refusing to give details. Denies any injuries except to face. Possible LOC. Now feels well. ,,OE: Haematomas to left forehead, centre forehead, left and right supraorbital ridges, right cheek and right jaw with associated skin wounds to right middle forehead, right supraorbital ridge and right suprauricular region. One wound to occiput also. ,,Pt refusing to stay in hospital and has self discharged but allowed me to close his occiput wound with a staple and the right supraorbital ridge wound with 1 x 5/0 interupted suture. ,,Any queries please contact A&E Reception on 0131 242 1300

Surname/Forename	Speirs, George
UHPI Number	500807310M

Episode Number	04110376

Note Details	Clinical Notes
Emergency Care Note Episode/Ref: E3285056 Mandy Coxhead 31/05/2016 21:11 Mandy Coxhead X	, ,Clinical note: Attends with deep laceration to upper lip after being involved in a fight at approx 1800 on Sunday 30th May. Pt has cleaned wound with salty water and a cotton bud since. Pt states that he was hit with an object but does not know what it was. Denies head injury but states fell landing on Right side and has bruising to his ear. Felt nauseas at time of injury which resolved. Denies feeling dizzy/lightheaded. No headache. Feels well. SAS called and attended scene - pt declined to travel.,,PMH - Nil,Meds - Nil,Allergies - Nil known,ATTB - covered,,O/E Neuro - GCS 15/15 T36.7 P67 Bp 129/84 O2 sats 99%ra RR16 ,PERL (4) - FROEM - no nystagmus/diplopia.,= movement x 4 limbs - no parathesia/weakness.,No bleeding/discharge ears or nose,No cspine tenderness - FROM neck. ,,Right ear - No mastoid tenderness/bruising. Skin intact. Brusing to pinna. No haematoma. ,,Upper lip - deep lac to underside. No vermillion border involvement. Wound sloughy appearance. Not red or hot to touch. ,No bony tenderness to Zygoma or mandible. Bite normal. No loose teeth. Pt states no problems with eating and drinking since. ,,Pt review by Dr McAlpine AE Cons - No further treatment required. Wound normal healing process. Wound to close by secondary intention. ,,Imp - Lip lac and bruising to Right ear.,,Management - Wound advice given, analgesia (pts own), tcasos,,Any queries please contact A&E Reception on 01506 523011 ,

Surname/Forename	Speirs, George
UHPI Number	500807310M

Episode Number	04110376

Note Details	Clinical Notes
A&E Notes Episode/Ref: E3325879 Leon Amos 24/07/2016 07:14 Leon Amos (NMR)	CHI : 0409781118,,37 year old male.,,PMH - Nil. Meds - Nil. NKDA.,,PC - dog bite to lower lip. Pt reports that he was bitten by his own rottweiller this evening.,,O/E - Looks well. 2 x oblique wounds to lower lip which both cross the vermillion border. Wound to central lower lip measures approx 2cm x 1cm. WOund to right side of lower lip measures approx 1cm x 0.2cm. Wounds not activelty bleeding. No FB observed in wounds. NO intraoral wounds or swelling.,,IMP - Dog bite lower lip.,,D/W Plastics.,,PLAN - Thorough wound lavage. CO-amoxicalv 625mg PO TDS. TO attend ward 18, SJH, 0830hrs next day. Advised fast from midninght.,,Leon Amos,Nurse Practitioner

Surname/Forename	Speirs, George
UHPI Number	500807310M

Episode Number	04110376

Note Details	Clinical Notes
A&E Notes Episode/Ref: 04110376 Dr Louisa Marshall 13/05/2004	25 year old RHD punched door earlier today. Pain/ swelling and deformity in right hand since.,,PMH/ Meds nil of note,,OE - bruising/swelling and deformity dorsum of right hand,nv intact distally,FROM all fingers/thumb,Tender over 4th/5th MC's,,XR dislocation 4th MC/Carpel joint,,REFER ORTHO - manipulation under local - re-located remains unstable.,Ortho to arrange for K-wiring.,,ORTHO ,Imp; Carpo MC dislocation right ring finger + acute boutonniere deformity right ring finger.,,Plan: Admit fasted from midnight tomorrow morning for K wiring right ring finger MC +/- repair central tendons slip right ring finger.,,Mr Simpson.

Surname/Forename	Speirs, George
UHPI Number	500807310M

Episode Number	04110376

Note Details	Clinical Notes
A&E Notes Episode/Ref: E046060 Dr AF Murray 24/06/2006	HISTORY: 27 year old RHD delivery man, up-to-date with tetanus, normally fit and well. Assaulted this morning sustaining an injury to right ring finger ? with stanley knife.,,O/E: Right ring finger - 1 cm laceration to medial (ulna) aspect of distal phalanx. Altered sensation to medial aspect of distal phalanx. Tender DIPJ + distal phalanx with decreased ROM at DIPJ. Nail has been lifted up from the nail bed and lying over skin.,,x-ray shows comminuted fracture to the tip of distal phalanx.,,Plan: wound cleaned, dressing applied. Oral Augmentin.,D/W Plastics SHO SJH who will kindly review SJH Ward 18 8 am mane,x-rays with patient,vh

Surname/Forename	Speirs, George
UHPI Number	500807310M

Episode Number	04110376

Note Details	Clinical Notes
A&E Notes Episode/Ref: E534930 Lynsey Faichney 18/07/2007	HISTORY: 28 year old usually fit and well. Up on a roof, 1 storey building retrieving football. Lowering self from roof and dropped approx. 6 ft. Landed awkwardly on his right foot. Unable to fully weight bear on foot since.,,PMH/drugs; nil,allergies: nil,SH: U/E. ,,O/E: Well. ,Bruising medial and lateral malleolus and plantar fascia,Tender calcaneum on the right. Tender right mid foot. NV intact distally.,AT clinically intact. FROM ankle.,,x-ray calcaneum and foot - avulsion fracture of the posterior talus.,,IMP: Fractured talus on the right.,,Plan: Crutches, F/C ,x-rays with patient,,

Surname/Forename	Speirs, George
UHPI Number	500807310M

Episode Number	04110376

Note Details	Clinical Notes
A&E Notes Episode/Ref: E586944 Dr Craig Davidson 23/01/2008 Karen Speed	29 yo male.,,PMH: NIL,,2 pm punched mirror while drunk as she discovered her home broken into.,,Attends > 6 hours later with wound over L little finger MCPJ.,,OE: The wound looks dirty and erythematus. ,3 cm oblique lac to MCPJ, FROM. ,Altered sensation on the medial edge of little finger.,XR shows possible FB and deeper into the wound.,,OE: Under ulna nerve block and locally injected lidnocaine. ,No FB seeen. ,Washed with assistance of SPR Enright. No FB seen.,Check XR still shows small possible FB deep into the wound.,The pt wants the wound closed and understands the risk regarding possible nerve damage.,The wound was closed with 3 x 4.0 ethilon sutures and steristrips. Good result.,The pt knows the FB may be present deeper in wound and was d/c with a one week course of coamox 625 po.,,,ks

Case Notes

Mental Health Assessment Service
Royal Edinburgh Hospital
Morningside Terrace
Edinburgh
EH10 5HF

Dr Ainsworth
Gracemount Medical Practice
24 Gracemount Drive
Edinburgh EH16 6RN

Date Dic: **18/10/2008**
Date Typed: **20/10/2008**
Ref: **FS/jg** 339207.

Direct line: **0131 537 6463**
Direct fax: **0131 537 6467**

Dear Dr Ainsworth

Re: George Speirs Dob – 04/09/1978 CHI No: 040 978 1118
126 Gilmerton Dykes Road, EDINBURGH EH17 8PE

Mr Speirs presented today to the Mental Health Assessment Service at the Royal Edinburgh Hospital. Mr Speirs reports a four month history of increased irritability, agitation, and breathlessness. He gives a history of binge drinking when he was released from prison on the 15th July; he has been in and out of prison all his adult life. Since July his sister has died and more recently last week his uncle. He has been coping with this with the excessive use of alcohol and valium purchased off the street. Mr Speirs main concern is his poor management of his temper stating the least thing sets him off. He feels he can no longer cope with his change in behaviour.

His present social circumstances:
He is currently living on friends couches as he and his partner have recently split up due to his behaviour. He is in receipt of benefits, he says his finances are Ok and he is not in any debt. He spends his days sleeping or drinking. He has two sons and has contact with them. He reported both his parents have alcohol problems which resulted in him mainly being brought up in foster care. He also states that his siblings have all either alcohol or drug habits.

Past psychiatric history:
He has no previous contact with psychiatric services though he reported to myself that he had been prescribed antidepressants in the past to little effect. His partner gave the view that he used to be a great person, very reliable and able to care for their child without difficulty, now she cant have him at home or around the child due to his explosive temper unpredictability and paranoia. Alcohol use was variable, he said that he would not have any alcohol for a few days and then binge on vodka and valium.

Mental state examination:
He was tidy and well presented, clean neat and appropriately dressed. He was anxious throughout the interview and very alert and acutely aware of what was being said. His speech was of normal tone rate and volume. There was some generalised paranoia which he said fluctuated depending on who he was with. There were no fixed delusional ideas, no

over-valued ideas and no auditory or visual hallucinations. Cognitively he presented as intact. His insight was intact at present.

His risk to self is such that he has self-harmed under the influence of alcohol. No self-harm or suicidal thoughts presently. He has a history of extreme violence and has severed custodial sentences for the same. He reports to have no charges pending at present.

Formulation of presenting problem:
Four month change in behaviour after bereavement since release from prison. Increased alcohol intake resulting in blackouts. Anger management is not effective any more.

Management plan:

1. Follow-up at MHAS on 21st October, 2pm.
2. Follow-up with Sector services, and a request for referral to sector services if nor been completed already.

Mr Speirs was given information on ELCA and Breathing Space at his request for exploration of counselling options.

Yours sincerely

Fiona Sime
Nurse Specialist
Mental Health Assessment Team

NHS
Lothian

Doctor in Charge
Newbattle Medical Group
Blackcot
MAYFIELD
EH22 4AA

Mental Health Assessment Service
Royal Edinburgh Hospital
Morningside Terrace
EDINBURGH
EH10 5HF

Date Rcd: **01 November 2011**
Date Typed: **03 November 2011**
Our Ref: **DM/JK/ 339207**
CHI No: **040978 1118**

Direct Line: **0131 537 6463**
Direct Fax: **0131 537 6467**

Dear Doctor

Re: **George Spiers, (dob – 04/09/1978),**
33/3 Barn Park, Edinburgh EH14 3HX

Date seen: **31/10/11 at 1315hrs**
Derek Myers and David Flucker

Presenting Complaint:
Mr Spiers self presented to the Mental Health Assessment Service, Royal Edinburgh Hospital, with his partner due to concerns about mental state. He was apparently due in court today but this had been cancelled and re-scheduled for next week. He has a court case regarding an alleged incident involving someone who was assaulted with ABH and disfigurement. George denied any involvement with this and reported he had been out of prison for approximately one year and feels his life is on track. If he is convicted there is the possibility of a 5 year sentence and he said he would "crack up if I go back inside". He has been using alcohol and street valium to deal with the stress. He reported being in and out of jail since the age of 16 and has tried to move on since release last year. His current coping mechanisms are alcohol and valium. He had done some minor self harm to his left wrist when intoxicated.

Past Psychiatric History:
None.

Past Medical History:
Nil significant.

Current Medication:
Nil.

Personal/Social History:
Lives alone in Wester Hailes as part of his bail conditions which prevent him from living with his partner in Midlothian. He has a pending trial next week. He is currently employed with the council part time.

Drug and Alcohol Use:
Reported drinking up to a bottle of vodka daily over the past 3 weeks. He uses street valium frequently. He reported that these make him feel better for approximately 2 hours and then he begins to ruminate again on his current situation. He had consumed approximately 3 pints before seeing us today.

NHS
Lothian

2.

Re: George Spiers, (dob – 04/09/1978),

Mental State Examination:
He was casually dressed, wearing a black suit, and was well kempt. He made good eye contact and easily engaged. There was no evidence of formal thought disorder. Speech was spontaneous and normal in rhythm, rate and tone. He described his mood as worried and his affect was reactive. He described broken sleep but his appetite was okay. Thought content – he is worried about a pending court case and will "crack up" if convicted and sentenced next week. No psychotic symptoms evident. Cognitive function appeared grossly intact and he was alert and orientated to time, person and place. Attention and concentration were fair. Insight was fair. Judgement appeared intact and there was no active suicidality at present.

Risk:
Self harm in recent weeks when intoxicated. Risk of misadventure due to alcohol and substance misuse.

Summary:
A 33 year old male, with no previous psychiatric history, presented to MHAS with partner after a court date was cancelled today due to partner's concern about mental state and risk issues. On assessment has increased worries about him using alcohol/street valium to deal with anger and agitation associated with pending court date. No active suicidal plan or intent. No psychotic symptoms evident.

Impression:
Situational crisis/alcohol and drug misuse.

Plan:
1. Discharged from MHAS.
2. Suggested he register with a local GP if planning to remain in Edinburgh.
3. Faxed GP to suggest possible medication to decrease agitation.
4. Psych ed given on alcohol and drug use.

Yours faithfully

Derek Myers
Nurse Specialist - Mental Health Assessment Service

over-valued ideas and no auditory or visual hallucinations. Cognitively he presented as intact. His insight was intact at present.

His risk to self is such that he has self-harmed under the influence of alcohol. No self-harm or suicidal thoughts presently. He has a history of extreme violence and has severed custodial sentences for the same. He reports to have no charges pending at present.

Formulation of presenting problem:
Four month change in behaviour after bereavement since release from prison. Increased alcohol intake resulting in blackouts. Anger management is not effective any more.

Management plan:

1. Follow-up at MHAS on 21st October, 2pm.
2. Follow-up with Sector services, and a request for referral to sector services if nor been completed already.

Mr Speirs was given information on ELCA and Breathing Space at his request for exploration of counselling options.

Yours sincerely

Fiona Sime
Nurse Specialist
Mental Health Assessment Team

Edinburgh CHP

TO/ NEWBATTLE HEALTH CENTRE

Mental Health Assessment Service
Royal Edinburgh Hospital
Morningside Terrace
Edinburgh
EH10 5HF

www.nhslothian.scot.nhs.uk

NHS Lothian

654 0665.

FAX COMMUNICATION from: D KLUCKER.

DATE:

☑ Mental Health Assessment Service
Royal Edinburgh Hospital

Tel: 0131 537 6463
Fax: 0131 537 6467

☐ Mental Health Assessment Service
Royal Infirmary of Edinburgh

Tel: 0131 242 1414
Fax: 0131 242 1416

Dear : DUTY DR.

Name : GEORGE SPEIRS.

CHI : 0409781118

This is a fax communication regarding the above named patient who was referred to the Mental Health Assessment Service by : HIMSELF.

A full assessment letter will follow detailing our assessment. This fax is meant only to confirm contact and briefly outline outcomes from the assessment.

Additional Information

CURRENTLY UNDER A LOT OF STRESS DUE TO UP-COMING COURT CASE, HAS INCREASE HIS ALCOHOL USE TO TRY AND BLOCK THINGS OUT. IN + OUT OF PRISON SINCE 16 YRS OLD.
HAST CSA
WORKING FOR 18 MONTHS SINCE D/C FROM PRISON, WORRIED THAT HE WILL GO BACK TO PRISON FOR SOMETHING HE HAS NOT DONE,
FEELS HE IS LOOSING EVERYTHING, BECOMING ANGRY,
HE MAY BENEFIT FROM SOMETHING TO HELP HIM FEEL LESS STRESSED.
EG. SMALL DOSE OF CHLORPROMAZINE 25mg TDS 50mg NOCTE.

339207

NHS Lothian Adult Mental Health Services **Mental Health Assessment Service**

BASIC INFORMATION

SECTIONS 1-3 TO BE COMPLETED BY ASSESSING NURSE:

1. PATIENT DETAILS:

Please circle

Surname:	Speirs	Sex:	Male ✓	Female	Not specified
First name:	George	Title:	Mr		
CHI:		Surname at birth:	/		
DOB:	4/9/78	Other previous surname:	/		
MHI:	0409781118	Ethnic Group:	/		
Address:	c/o 126 Gilmerton Dykes Road	First Language:	English		
		Occupation:	/		
Postcode:	EH17 8PE	Religion:	/		
Phone:	0131 258 1826	Address Type:	Permanent / Temporary		
		UK resident 12 months:	(Yes) / No		

2. GP DETAILS:

GP:	Dr Ainsworth
Practice:	
Practice Address:	Gracemount Medical Centre
Postcode:	EH16
Phone:	6642377
Fax:	~~6722114~~ 6722114

3. NEXT OF KIN / NAMED PERSON DETAILS:

Surname:	~~Em~~ Tait
First name:	Emma
Relationship:	ex partner
Address:	126 Gilmerton Dykes Rd
Postcode:	EH17 8PE
Phone:	0131 258 1826.

NHS Lothian Adult Mental Health Services **Mental Health Assessment Service**

PART 1: ASSESSMENT OF NEED FOR ADMISSION **SECTION 1:** Patient details and presenting problem

TO BE COMPLETED FOR ALL PATIENTS BY ASSESSING NURSE:

Name: George Speirs	**MHI:**	**DOB:** 4/9/48

Date: 18-10-08	**Time:** 1510
Assessor's name: Fiona Sime	
Assessor's profession: RMN.	**Grade:** 6.
Other assessor's name (if present):	
Other assessor's profession:	**Grade:**
Referred By: Self	**Assessment at:** (REH) / RIE / CMHT / IHTT / Other

Names of those currently involved:		**Personal strengths & supports** including usual coping strategies, care package and resilience factors:
Keyworker:		
Consultant:		
MHO:		
CPN:		
Advocate:		
Primary carer:		

Reason for referral: Referral letter Yes (No)

Been to GP repeatedly since release can't cope with ↑ temper, ↑ alcohol, doesn't feel in control, agitated + restless.

Presenting complaint / history of presenting complaint:

Binge drinking.

July 15th discharged/released from prison

Since then loss of sister + uncle. + Alcohol and valium

Feels he will do something

July 15th 4mth sentence. Been in and out prison all his life.

↑ Anger

Recent symptoms (including sleep, appetite, concentration, energy and mood):

Sleep - Only when out on alcohol or valium.
Appetite - Anxious, vomitting often what he eats.
Concentration - vv poor
Energy - vv poor.
Mood - Angry

PART 1: ASSESSMENT OF NEED FOR ADMISSION **SECTION 2:** Further history, medication and substance use

TO BE COMPLETED BY ASSESSING NURSE:

Name: George Speirs	MHI:	Date: 18/10/08

Present social circumstances including accommodation, finances, employment, daytimes activities, support, relationship in home:

Currently living with on friends benefits, finances ok no debt, sleeping or drinking during the day. Relationship broken down has 2 sons and contact with them. Both parents have

Past medical history: alcohol problems - brought up in foster care. Siblings have drug habbits.

Poor engagement with GP: Yes / No

Past psychiatric history including diagnosis, previous admissions, previous treatment and use of MHA:

No previous contact with psych services thou reports GP's have prescribed anti-depressants in the past.

NHS Lothian Adult Mental Health Services **Mental Health Assessment Service**

Carer's view and relevant information from others including carers, advocate, CPN, key worker: 'ex partner' Helluse to be great!! Now she can't have him at home or around their child. Explosive temper, unpredictable, paranoid.

Current medication including OTC medicines:

Source: Patient / Carer / GP / Pharmacist / Notes / Other

Alcohol use: Binge for days then nothing.

Risk of dependence / withdrawal: Yes (No)

Other substance use: Valium nothing else. Variable amount.

Smoker: No / Ex / (Current) 10 / day

PART 1: ASSESSMENT OF NEED FOR ADMISSION **SECTION 3:** Mental state and risk assessment

TO BE COMPLETED FOR ALL PATIENTS BY ASSESSING NURSE:

Name: George Speirs	MHI:	Date: 18/10/08

MENTAL STATE EXAMINATION

Appearance: Tidy well presented clean + neat approprate	**Attitude and behaviour:** Anxious, very alert
Speech / Communication: Normal TRV **Problem with English:** Yes (No)	**Mood / Affect:**
Thought Content / Process: Paranoia generalised variable.	**Perceptual Abnormalities:** No delusions, Nover valued ideas, No AH or VH.
Cognitive Examination: Intact.	**Insight / Judgement:** Intact at present.

IMMEDIATE RISK SCREENING

Risk to self including self harm, suicide: Yes (No)
Has self harmed under influence of alcohol
No self harm, suicide thoughts presently

Risk to others including aggression, violence, homicide: (Yes) No
History of extreme violence, custodial sentence for same.

Risk to children including neglect, abuse, on at risk register: Unknown Yes / No

Alerts from PiMS / F2	Yes / No	**Risk from others** e.g. abuse, exploitation, domestic violence	Yes / No
Physical impairment e.g. wandering, falls, sensory impairment	Yes / No	**Risk of neglect** including personal health	Yes / No
Memory / Cognitive impairment	Yes / No	**Challenge to services** e.g. inappropriate demands, poor service response	Yes / No
OVERALL RISK			HIGH / MEDIUM / LOW / NOT KNOWN

ALL IDENTIFIED RISKS MUST BE ADDRESSED IN THE CARE PLAN

NHS Lothian Adult Mental Health Services | Mental Health Assessment Service

PART 1: ASSESSMENT OF NEED FOR ADMISSION | SECTION 4: Formulation, decision making and use of MHA.

TO BE COMPLETED BY ASSESSING NURSE:

Name: George Spiers	MHI:	Date: 18-10-08

Formulation of presenting problem:
Change of behaviour after bereavement and since release from prison. Increase in alcohol intake black outs, Anger management not affective any more.

Patient's preferences for treatment:
No admission.

Diagnoses:	ICD-10 Codes:

Management plan with rationale for decision and alternatives considered: Admit / IHTT / Review / Other
Follow up MHAS 21/10/8 2pm.
Follow up with sector services, request referral if not done by GP already.
Info on ELCA and Breathing space for short term. Explore counselling options.

MENTAL HEALTH ACT:

Patient already subject to community based detention?		Yes / (No)
Section		Hospital based / Community based
Expiry date (check in PiMS if not known)		
Patient detained in hospital following this assessment?		Yes / (No)
Name of detaining doctor		
Section		
Expiry date		Expiry time
Mental Health Officer	Yes / (No)	Name:
		Address:
		Phone number:
Named person:	Yes / (No)	Name:
		Address:
		Phone number:
Advance statement:	Yes / (No)	Details:

Assessor name:	F SIME	Assessor signature:	F Sime

END OF PART 1: ASSESSMENT OF NEED FOR ADMISSION

Mental Health Assessment Service Post Assessment Intervention	Name George Speirs
	DoB 4/9/78
	MHI/Unit No.

Date / Time

21/10/08 2pm. Mr Speirs attended for follow-up visit as arranged on 18/10/08.

Since initial visit reported no further use of illicit benzodiazepines and reported continued use of alcohol however not to the same extent.

Mr Speirs continued to be guarded about cause of anger/irritability and initially reported no current stressors.

Over course of interview Mr Speirs disclosed an incident of abuse (sexual) when he was 14 years of age. He has never spoke with anyone regards this and still feels this is something he could not address. He finds this incedent is more predominately in his thoughts and is having flash backs to this time.

Mr Speirs agreed that although he successfully completed an Anger Management course whilst in prison this was such a long time ago he agreed he could benefit from repeating this process.

F Se s/N
RMN.

Mental Health Assessment Service Post Assessment Intervention	Name
	DoB
	MHI/Unit No.

Date / Time	

INITIAL ASSESSMENT

NHS Lothian

1. Personal details

Date of assessment: 31 / 10 / 11

Surname	Spiers
First name	George
Preferred name	
CHI	04.09.78 1118
Date of birth	4.9.78
MHI	335 207
Address	33/3 Barnpark
	Edinburgh
Postcode:	
Telephone no:	

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

2. GP details

GP	
Practice	Newhaven M.P.
Practice address	Blackmoat
	May field.
Postcode:	
Telephone no:	
Fax no	

3. Next of Kin

Is NOK the named person? Yes / No

Surname:	not provided.
First name	
Relationship:	
Address:	
Postcode:	
Telephone no:	

Alerts

(e.g. allergies, safety issues)

ICD 10 category

4. Legal status

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

5. Admission details

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

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

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

Name: George Spiers	CHI: 040978 1118	Date: 31 / 10 / 11

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

Name	Relationship / Role	Address / telephone number/ e mail

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

Name	Relationship / Role	Address / telephone number/ e mail

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

HCP only.

8. Assessor details

Time of assessment (24hr clock):	1315 hrs	Location of assessment:	ADC
Primary assessor:	Derek Myers	Designation:	RMN
2nd assessor:	David Plucker	Designation:	RMN
Assessing team:		Referred by:	self

Factors affecting assessment (e.g. intoxication):

BAC:

9. Physical identifiers

General appearance: black suit + black tie - white t-shirt		Distinguishing features:	
Hair colour:	brown	Height: 5'9"	Build: athletic
Eye colour:	brown	Dentition:	own.

Name: George. Speirs	CHI: 0409781148	Date: 31 / 10 / 11

10. History of presenting complaint

33 of in relationship, living alone, no previous Hx, managed by GP - Self presented to MHAS c partner due to concerns about mental state. Was apparently due $ in court today but this was cancelled + rescheduled for next week. Has court case regarding an alleged incident. That involved someone who was assaulted c ABH + disfigurement - George denied any involvement in this.

Person's view of current situation: 'I'll crack up if I go back inside' Reports possibility of 5 year sentence. Using alcohol + street valium to deal c stress. Reports being in + out of jail since 16 - has tried to move on since release last year.

Person's usual ways of coping and strengths: Current crisis plan? Yes / No

- alcohol / valium - minor self harm when intoxicated.

Spiritual beliefs / needs:

Family history: Not explored

Personal history:

Name: George Speirs	CHI: 040978 1118	Date: 31 / 8 / 11

Social circumstances lives alone in west Lothian as bail conditions prevent him from living t partner in Midlothian. Pending trial next week - currently employed t Council PT.

Past Medical History & current physical health:

- Nil

Past Psychiatric history:

- Denies.

Carer's view of current situation (including carer's usual role): - father concerned about pt's behaviour - often 'He's cracking up'

Does carer live at same address? Yes / No

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

- No Rx currently.

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

Alcohol use (note quantity): drinking up to bottle of vodka daily over past ~~the~~ 3/52.

Risk of dependence / withdrawal: Yes / No

Other substance use: street valium - on frequent basis.

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

Risk of dependence / withdrawal: Yes / No

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

Name: George Speirs	CHI: 040978 1118	Date: 31 / 10 / 11

11. Assessment

Current mental state

Appearance & behaviour Casually dressed - wearing black suit - well kept - good EC, easily engaged.

Speech, communication, any thought disorder → N.A FTD.
↳ (N) R/R/T

Mood / affect (including sleep and appetite)
Mood - worried
Affect - Reactive.
Sleep - 'broken'.
Appetite - 'ok'

Thought content, abnormal beliefs, abnormal experiences
- worried about pending court case + that will 'crackup' if convicted ~~of~~ + sentenced next week.
N.A Psychotic Sx evident.

Cognitive function → appears intact
alert + oriented T/P/P.
Attention/Concentration Fair.

Insight, judgement → appears intact - no active suicidality @ present.
↳ Fair

12. Risk Screening

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

Further investigation required? ☐ Yes ☐ No By Whom?

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

- Self harm in recent weeks when intoxicated. Misadventure due to alcohol ~~substance~~ misuse + ~~alcohol~~ use. Substance.

Further investigation required? ☐ Yes ☐ No By Whom?

Name: George Spears	CHI: 040978 1118	Date: 31 / 10 / 11

12. Risk Screening continued

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

Further investigation required? ☐ Yes ☐ No By Whom?

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

Further investigation required? ☐ Yes ☐ No By Whom?

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

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

Further investigation required? ☐ Yes ☐ No By Whom?

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

Further investigation required? ☐ Yes ☐ No By Whom?

Risks relevant to service providers ☐ Yes ☒ No ☐ Unknown

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

Further investigation required? ☐ Yes ☐ No By Whom?

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

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

Name: George Speirs	CHI: 040978 1118	Date: 31/10/11

13. Summary & plan

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

~~700~~ 33 ~~07~~ - no previous Hx - presents to MHTS ↑partner after court date cancelled today + due to partner's concerns about mental state/risk issues. On assessment has ↑'ed worry + worry alcohol / street valium to deal ↑ anger + agitation assoc. ↑ pending court date. No active suicidal plan / intent.

Formulation /diagnosis

Impression: Situational Crisis / alcohol + drug misuse.

Person's desired immediate outcome(s):

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

Comment:

Management plan (inc. plan to manage identified risks)

1) DIC MHTS - suggested to register ↑ Edinburgh GP if planning to remain in Edinburgh.

2) Fax GP re: Suggest possible Rx to ↓ agitation.

3) ↑'ed given on alcohol / drug use.

Discussed with:

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

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

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

Assessor- Name/Grade:	Signature:	Date:
(Mears) RMN	'G'	31/10/11

Immediate needs relating to admission to hospital

Name:	CHI:

This form should be completed with the service user and /or carer <u>before</u> admission to hospital

1. Informing significant others

(include carers, Named person, existing advocate and others that person wishes to be informed about their admission)

Name	Relationship / Role	Address / telephone number/ e mail	Informed?

2. Social circumstances / daily living

Detail any immediate issues that need addressed caused by admission to hospital
(e.g. impact on work, benefits, child care, housing, caring role, pets care etc)

Need	Action(s) required

3. Culture, spirituality & language

Detail any immediate needs relating to the person's culture, spiritual beliefs or language
(e.g. food, prayer/worship, beliefs, need for interpreter)

Need	Action(s) required

4. Any other relevant information

Name/Grade:	Signature:	**Date:** ___ / ___ / ___ **Time** (24hrs): ___ : ___

Clinic Letters & Notes

Mental Health Assessment Service
Royal Edinburgh Hospital
Morningside Terrace
Edinburgh
EH10 5HF

Dr Ainsworth
Gracemount Medical Practice
24 Gracemount Drive
Edinburgh EH16 6RN

Date Dic: **18/10/2008**
Date Typed: **20/10/2008**
Ref: **FS/jg/ 339207**

Direct line: **0131 537 6463**
Direct fax: **0131 537 6467**

Dear Dr Ainsworth

Re: George Speirs Dob – 04/09/1978 CHI No: 040 978 1118
126 Gilmerton Dykes Road, EDINBURGH EH17 8PE

Mr Speirs presented today to the Mental Health Assessment Service at the Royal Edinburgh Hospital. Mr Speirs reports a four month history of increased irritability, agitation, and breathlessness. He gives a history of binge drinking when he was released from prison on the 15th July; he has been in and out of prison all his adult life. Since July his sister has died and more recently last week his uncle. He has been coping with this with the excessive use of alcohol and valium purchased off the street. Mr Speirs main concern is his poor management of his temper stating the least thing sets him off. He feels he can no longer cope with his change in behaviour.

His present social circumstances:
He is currently living on friends couches as he and his partner have recently split up due to his behaviour. He is in receipt of benefits, he says his finances are Ok and he is not in any debt. He spends his days sleeping or drinking. He has two sons and has contact with them. He reported both his parents have alcohol problems which resulted in him mainly being brought up in foster care. He also states that his siblings have all either alcohol or drug habits.

Past psychiatric history:
He has no previous contact with psychiatric services though he reported to myself that he had been prescribed antidepressants in the past to little effect. His partner gave the view that he used to be a great person, very reliable and able to care for their child without difficulty, now she cant have him at home or around the child due to his explosive temper unpredictability and paranoia. Alcohol use was variable, he said that he would not have any alcohol for a few days and then binge on vodka and valium.

Mental state examination:
He was tidy and well presented, clean neat and appropriately dressed. He was anxious throughout the interview and very alert and acutely aware of what was being said. His speech was of normal tone rate and volume. There was some generalised paranoia which he said fluctuated depending on who he was with. There were no fixed delusional ideas, no

over-valued ideas and no auditory or visual hallucinations. Cognitively he presented as intact. His insight was intact at present.

His risk to self is such that he has self-harmed under the influence of alcohol. No self-harm or suicidal thoughts presently. He has a history of extreme violence and has severed custodial sentences for the same. He reports to have no charges pending at present.

Formulation of presenting problem:
Four month change in behaviour after bereavement since release from prison. Increased alcohol intake resulting in blackouts. Anger management is not effective any more.

Management plan:

1. Follow-up at MHAS on 21st October, 2pm.
2. Follow-up with Sector services, and a request for referral to sector services if nor been completed already.

Mr Speirs was given information on ELCA and Breathing Space at his request for exploration of counselling options.

Yours sincerely

Fiona Sime
Nurse Specialist
Mental Health Assessment Team

NHS Lothian

Doctor in Charge
Newbattle Medical Group
Blackcot
MAYFIELD
EH22 4AA

Mental Health Assessment Service
Royal Edinburgh Hospital
Morningside Terrace
EDINBURGH
EH10 5HF

Date Rcd: **01 November 2011**
Date Typed: **03 November 2011**
Our Ref: **DM/JK/ 339207**
CHI No: **040978 1118**

Direct Line: **0131 537 6463**
Direct Fax: **0131 537 6467**

Dear Doctor

Re: George Spiers, (dob – 04/09/1978),
33/3 Barn Park, Edinburgh EH14 3HX

Date seen: **31/10/11 at 1315hrs**
Derek Myers and David Flucker

Presenting Complaint:
Mr Spiers self presented to the Mental Health Assessment Service, Royal Edinburgh Hospital, with his partner due to concerns about mental state. He was apparently due in court today but this had been cancelled and re-scheduled for next week. He has a court case regarding an alleged incident involving someone who was assaulted with ABH and disfigurement. George denied any involvement with this and reported he had been out of prison for approximately one year and feels his life is on track. If he is convicted there is the possibility of a 5 year sentence and he said he would "crack up if I go back inside". He has been using alcohol and street valium to deal with the stress. He reported being in and out of jail since the age of 16 and has tried to move on since release last year. His current coping mechanisms are alcohol and valium. He had done some minor self harm to his left wrist when intoxicated.

Past Psychiatric History:
None.

Past Medical History:
Nil significant.

Current Medication:
Nil.

Personal/Social History:
Lives alone in Wester Hailes as part of his bail conditions which prevent him from living with his partner in Midlothian. He has a pending trial next week. He is currently employed with the council part time.

Drug and Alcohol Use:
Reported drinking up to a bottle of vodka daily over the past 3 weeks. He uses street valium frequently. He reported that these make him feel better for approximately 2 hours and then he begins to ruminate again on his current situation. He had consumed approximately 3 pints before seeing us today.

2.

Re: George Spiers, (dob – 04/09/1978),

Mental State Examination:
He was casually dressed, wearing a black suit, and was well kempt. He made good eye contact and easily engaged. There was no evidence of formal thought disorder. Speech was spontaneous and normal in rhythm, rate and tone. He described his mood as worried and his affect was reactive. He described broken sleep but his appetite was okay. Thought content – he is worried about a pending court case and will "crack up" if convicted and sentenced next week. No psychotic symptoms evident. Cognitive function appeared grossly intact and he was alert and orientated to time, person and place. Attention and concentration were fair. Insight was fair. Judgement appeared intact and there was no active suicidality at present.

Risk:
Self harm in recent weeks when intoxicated. Risk of misadventure due to alcohol and substance misuse.

Summary:
A 33 year old male, with no previous psychiatric history, presented to MHAS with partner after a court date was cancelled today due to partner's concern about mental state and risk issues. On assessment has increased worries about him using alcohol/street valium to deal with anger and agitation associated with pending court date. No active suicidal plan or intent. No psychotic symptoms evident.

Impression:
Situational crisis/alcohol and drug misuse.

Plan:
1. Discharged from MHAS.
2. Suggested he register with a local GP if planning to remain in Edinburgh.
3. Faxed GP to suggest possible medication to decrease agitation.
4. Psych ed given on alcohol and drug use.

Yours faithfully

Derek Myers
Nurse Specialist - Mental Health Assessment Service

Radiology Reports

XR Skull

XR Skull

Clinical details

Alleged assault||Temporal bone tenderness ++

Report

Skull Series

No vault fracture seen.

Kathryn Stewart
Advanced Practitioner

KS/CB

Reporting Radiologist: Kathryn Stewart

Report Information

Requestor	
Requesting Location	(RIEAE3) 3 - Exam, A&E
Report Identifier	6618329
Sample Date	09/01/2010 04:13:00