

FORMATIVE EVALUATION

UNIT No.

PATIENTS NAME Emma Lindsay

DATE OF BIRTH

WARD/DEPARTMENT

SIGNATURE/DESIGNATION

DATE	FORMATIVE EVALUATION	SIGNATURE/DESIGNATION
2/9/05	<u>Plan</u> 1. Home Saturday night + to return Sunday evening * 2. nursing staff to phone to support Emma + mg with leave over the weekend (1x Sat night + 1x Sun lunch) 3. monitor MSE for vices/any objective evidence of distress. Inform if any concerns	
18/09/05	Emma has got up early this morning managed a bit of toast for breakfast and has attended all time tabled activities. Emma has appeared bright and settled in mood around the ward and pleasant to in manner when speaking with staff and peers. As Emma's trial model nurse I have met with Emma on various occasions today. Emma told writer she was "worried about her weekend passes" and "I don't think I can manage it is too much." Writer advised Emma to to speak with Dr Forsythe and also suggested that she might give her passes a try and if she is struggling she could phone the ward for support or return early. Emma told writer this was something she could try. Emma met with me and is now to have one overnight pass to which she told writer she was pleased with. Emma has managed a good dietary intake today.	SPK
3rd Sep 05 05:05	Emma appeared bright in mood with appropriate speech content and behaviour last night. She retired to bed at 23:30hrs and appears to have slept well.	N/A

DATE	FORMATIVE EVALUATION	SIGNATURE/ DESIGNATION
3.9.05 16 ⁰⁰ hrs Nursing	met with Emma several times today she expressed anxiety regarding her overnight pass. Request and was given 'as required' paracetamol 1g as per Kardex for headache. Emma stated that she felt the headache was due to the stress of the forthcoming pass. Phone call from 'stepmum' Mary informing staff that an overnight pass this weekend wasn't convenient and next weekend would be better. Agreed that it would be convenient for Emma to have a day pass tomorrow Emma's grandfather will collect her between 10-10.30 am.	
4 th Sept 05 06:10	Emma appeared bright in mood last night with appropriate speech content and behaviour. Interacting well with peers. retired to bed at 23:50hrs appears to have slept well.	e/n
14-15 th Nursing	Met with Emma for a short time today due to her being on pass for a time today. Emma had a home pass which Emma stated was "OK". Spoke for a short time about Emma's new bedroom at home and what colour's etc she was going to paint them. On return from pass Emma stated that she was feeling a bit down but is ok now. At time of writing Emma appears bright in mood and is mixing well with fellow peers.	W/S
5 th Sept 05 05:30	Emma was initially settled last night, watching T.V. and interacting well with fellow patients and staff alike. At approx 22:00hrs she became slightly agitated expressing her frustration about the unit, began throwing things about her room. Emma settled quickly following nursing intervention and being reminded that if her behaviour continued her room would be made safe by removal of movable objects. Apologised for her behaviour. Slept well from 22:40hrs.	W/S
13.00hrs	Met with Emma today as her Tidar nurse. Emma spoke about "feeling down" just now although she couldn't elaborate on why this was. Spending most of the day close by fellow peer S.C. trying to encourage him to attend activities in which she was interested for. They went out for cigarettes together and slept most of the afternoon on different couches in T.V. room. Is currently on art therapy.	W/S
6.9.05. 05:00.	Emma spent a settled evening about the ward, hanging out with S.C. in lounge or garden. No issues raised to staff.	S/N

FORMATIVE EVALUATION

PATIENTS NAME EMMA LYNDAY

UNIT No.

DATE OF BIRTH 26/08/90

WARD/DEPARTMENT ADU

DATE	FORMATIVE EVALUATION	SIGNATURE/DESIGNATION
6/9/05 NRS/ING	As Emma - Home today, we met this morning and completed review plan for her review tomorrow. (See review plan). We met again this evening. She stated she had an "ok day" but at times low. Emma appeared more concerned about her reports over last days, especially that she had been spending long periods with Jellies S.C. I pointed that this was true, which she then agreed and stated it was her "person" we talked briefly about this. She then put objection to having sleepover with Jellies in the evening and would not be staying this place as a change.	
7.9.05 0300	Emma has been settled though disgruntled, complaining of staff reporting inaccurately in the nursing notes. She has enjoyed the company of certain peers & has slept well.	S/N.
7.9.05.	Met up. Emma is doing very well - she is off all medications. Told me that Dr D'Senibe had met with her mother & told her nothing was wrong and that everything was behavioural. (Checked up on this - did not meet Dr D'Senibe but there was a meeting with Dr Explained to her that I do not think her symptoms are caused by schizophrenia - entered a conversation about Developmental Disorder of Personality - which she accepted very well. Explained that she may be vulnerable to becoming depressed from time to time. Praised her hugely for how much she has worked at recovery, eg anger management. Asked if she would get a discharge date at her review - I said yes + we agreed that there needs to be some planning. Hence this was.	
7/9/05	Review meeting. In attendance were Dr [unclear] Dr [unclear] Emma was praised on the progress she has made since admission. A provisional discharge date of 14th October has been set with a view to school.	

DATE	FORMATIVE EVALUATION	SIGNATURE/DESIGNATION
	in community being established. Overnight home visits to be continued. Dr Forsyth to liaise with community teams. Next review 12th October 2005 at 3.30pm.	
18/10	Met with Emma as per Tidel Model. Up and organised this morning. Emma unable to attend school as was upset at previous nursing note entries. Emma had long chat with NIA Donaldson about these issues. States mood has been "low at times but ok at others". States feels ok about discharge date which was set today at her review. Has spent time in company of peers S.C. and M.H. also L.M. Watching football and doing M.H. hair this evening.	
8/9/05 Nursing 6am	Emma has been settled in mood and behaviour. Spent time in T.V. room interacting with peers. No problems noted.	RMN
9/9/05 06:20 Nursing	Emma remains very settled in mood and behaviour. Spoke with S.W. McEnamara about discharge stating that she was looking forward to it and feels ready for discharge. feels she is also ready to go back to school, and no longer feels anxious regarding being off all medication. feels very positive towards the future. Spent most of the evening with peer S.C. Relaxed to bed and slept well overnight.	RMN
9/9/05 Nursing 8:20am	Day report from 8/9/05. Emma has had a settled day mostly. Attended some school but missed morning group. Mood settled and behaviour appropriate most of the day.	RMN
9/9/05	SPR: MEDICAL: Review meeting feedback to Clinical Nurse Specialist - CAMHS.	
	K.M. - knows family well - agrees diagnosis of probs & personality dev. feels at times Mrs Lindsay can be over-rigid & Emma & therefore was in agreement that work & family is required.	

Since admission, Emma has settled into the ward, showing very good insight into her difficulties. Initially Emma stated that she had 3 main issues that she wanted to work on, including, managing her auditory hallucinations, coping skills for self-harm and binge eating, which have all been addressed through nursing care plans. Emma has responded well to these nursing interventions, although at times requiring a lot of firm limit setting.

Initially Emma reported that her mood was mostly low, and voices were loud, particularly at night, resulting in some incidents of self-harm. However over the past 6 weeks, Emma's mood, has become more settled, with very few periods of low moods, and a decrease in self-harming behaviour noted. Emma has been able to approach staff when experiencing difficulties and has responded well to support and reassurance. Emma has been monitoring her mood and the intensity of her voices, through the use of a diary work, however continuously needing prompting to complete same. There doesn't appear to be any clear pattern or relationship with Emma's mood and her voices, and objectively there has been no evidence of pre-occupation with unseen stimuli.

Emma reports that a female voice in her head tells her to vomit, which she has acted on, over the past month. Emma states she feels lonely and angry before binge eating and just prior to self-induced vomiting, and describes a release from emotions and thoughts. Nevertheless, there has been a decrease in this behaviour recently, whereby Emma states that she feels able to distract herself, and challenge the negative thoughts most of the time. Emma has been commenced on a healthy eating plan, which she has found very difficult to comply with, requiring staff guidance and encouragement.

Overall, Emma's behaviour has become more settled around the ward since admission. Initially Emma became easily irritable and argumentative with both staff and peers, resulting in various incidents of verbal aggression and destroying property, thus requiring a lot of limit setting, which Emma admits to finding very difficult, but very helpful too. Emma has recently been very pleasant, interacting well with peers and staff most of the time, although noted to be quite over-familiar with male patients, requiring reinforcement of boundary issues. Attending to school timetable, groups/outings, and unaccompanied walks with no problems.

However, struggling to manage home passes. Emma was to have 2 overnight passes last weekend and was unable to manage same, stating that she felt it was 'too much'. Mums partner phoned the unit stating that the pass wasn't convenient for them either and wanted to change it to the next week, resulting in Emma going out on a day pass only. Objectively Emma is very settled in the ward, and has stated to staff that she doesn't want discharged.

Allops.



10.7 Patient ward round plan

DATE 7/9/05

NAME <u>Emma Lindbay</u>	MHA STATUS <u>informal</u>
DATE OF BIRTH <u>26/8/90</u>	OBSERVATION LEVEL <u>Genrel</u>
DATE OF ADMISSION:	LEAVE STATUS (<u>Inc Sect 17</u>)
CONSULTANT <u>Dr. Gennell</u>	NAMED PRIMARY NURSE
WHAT KEY ISSUES DO I WANT TO RAISE AT THE WARD ROUND? <u>Meds. if i am getting put on any thing else</u> <u>Disagree that I do not have psychotic episodes</u>	HOW HAVE THINGS CHANGED FOR ME OVER THE PAST WEEK OR SO? <u>SIX</u> <u>More settled</u> <u>Voices less</u> WHY IS THIS? <u>feel safe here</u>
ANY SPECIFIC REQUESTS? <u>Take at scene class</u>	ANY CONCERNS OR QUESTIONS ABOUT MY MEDICATION OR TREATMENT? <u>As above</u>
Am I happy for student nurses and/or student doctors to be present? YES [] <u>NO</u> []	

PATIENT'S NAME:	D.O.B.	UNIT No.	SIGNATURE/ DESIGNATION
DATE	MEDICAL PROGRESS NOTES		
9/9/05	Social work not involved as yet but will speak to team social worker to try to arrange a package -> ? befriending ? respite Re: School - also expressed concern about Emma's ability to manage - feels she will need support+++ she'll get Ed & involved - also suggest Excel group - for children in the area who are having difficulty & attendance. Plan: ① meeting arranged - to come no ward to meet & Emma on 21/9/05. ② DF to speak to School - Excel Group.		
			SPR.
9.9.05 5.25 pm	Emma states that her mood is "in the middle" today. Emma has spent time in the company of fellow peers for most of the day and noted to be relaxed and in good humor. particularly M.H. in the morning and L.M. and S.C. in the afternoon. Write asked Emma how she felt about her overnight pass tomorrow. Emma replied "fine". Write asked what had changed from last week as she was noted to be very ambivalent about her pass and did not merge. Emma stated her mum had put some distractions in place this week. Write asked what these distractions were and Emma explained that her cousins would be visiting. Write and		

DATE	FORMATIVE EVALUATION	SIGNATURE/ DESIGNATION
	was feeling⁴¹ insensitive and doesn't understand her problems and dismisses her experiences. Around 10 minutes later Emma found in bedroom with a bloody arm. Arm cleaned in treatment room, Emma had inflicted 8 to 10 superficial cuts to left inner arm. Steristrips required on a couple of wounds and arm dressed. N/A spent time with Emma after this incident. She stated she doesn't want to go home and feels self harm behaviour will result in her being kept in hospital. Settled and slept from around midnight.	
14/11	<u>8ho review</u> Emma very quiet & sullen this morning. Didn't say anything during discovery group. Had a fight with mum on the phone last night. Had declined to attend family meeting with mum/yesterday, and afterwards felt mum was "getting in her face". Feels mum doesn't give validity to her voices, telling her she should "be able to cope with them". Currently Emma says she doesn't want any contact with mum, and doesn't want mum informed of any clinical decisions. Says she does not want to go and live with mum on discharge and would "rather go into foster care". Self-harmed last night due to level of distress. Felt a bit disappointed with herself (first time in ~ 10/7) said she didn't go and speak to anyone instead because "I couldn't be bothered with them telling me that my mum cared about me". Talked to Emma about why coming to family work would be important: easier for mum & Emma to work out why they fight, with a 3rd party to mediate. Is supposed to be gay on overnight pass to mum's tonight → Currently rephrasing. See how things go over course of day, JK	

TEAM MEETING

(NAME) Emma Lindsay

KELVIN TEAM

(DATE) 13.09.05

Nursing Report

Emma reports her mood to be low but objectively mood is bright and settled.
Interacting well socially.
Developing romance with peer S.C.
Often refuses to attend groups.
Can be angry if she doesn't get her own way.
Struggles with healthy eating care plan.
Managed one overnight pass at weekend.

Medical Report

Dr [redacted] oke with nurse from CAMHS team [redacted] and will arrange
to meet her next week. Karen will liaise with CAMHS social work.

Current Psychotropic Medication and Working Diagnosis

Nil

Psychology Report

TEAM MEETING
KELVIN TEAM

(NAME) Emma Lindsay
(DATE) 13.09.05

Dietician Report

Occupational Therapy Report

Other Disciplines – Physio, Etc

School Report

Poor attendance for variety of reasons – can't be bothered, not well etc.
Able to function at Intermediate II level.
Own school are keen to have her back.
Emma's name will be put forward at next Joint Assessment Team meeting.
Possibility of part-time school placement.

Social Work Report/Family Work

Group Work Report

Risk Assessment

Decision and Pass Arrangements

- Increase time on pass
- Invite mainstream Guidance Teacher and Educational Psychologist to Discharge Planning meeting.
- Needs limits set re school attendance.
- Arrange visit to Guidance Teacher.

KEY POINTS AND ISSUES:

Emma reports that her mood continues to fluctuate, although objectively appears mostly settled & bright. Emma continues to report that she experiences bad thoughts, however no evidence of any pre-occupation with same. No self-harm or self-induced vomiting noted. Spending a lot of time in the company of peers, particularly peer SC.

At times can be quite oppositional with staff, particularly re handing in her mobile phone.

Requires a lot of limit setting and reminding of ward policies.

Continues to struggle with healthy eating-regime eats a lot of junk food.

Reluctant to attend all groups.

Went on pass at the weekend - says it was 'fine'.

RECOMMENDATIONS:

- Continue with overnight passes
- Continue to monitor mood + behaviour
- Encourage diary work
- Encourage healthy eating.

GREATER GLASGOW NHS BOARD - PRIMARY CARE DIVISION

FORMATIVE EVALUATION

UNIT No.

PATIENTS NAME EMMA LINDSAY

DATE OF BIRTH 28/8/90

WARD/DEPARTMENT ADV

SIGNATURE/ DESIGNATION

DATE	FORMATIVE EVALUATION	SIGNATURE/ DESIGNATION
14/9/05	Emma's mum rang to arrange for Emma's granddad to pick her up for overnight pass today. However Emma does not wish for this to go ahead and is unwilling to change her mind or to have any contact with her mum at present. Mum informed of this and accepting however still plans that the pass for this weekend, Saturday, will go ahead.	RMN
14/9/05	Met with Emma several times in the morning at 10.30am for held model. At approximately 10.30am Emma approached me & stated she was telling her & requested for as required child protection medication. Discussed issues surrounding her for model release to her argument with her mother last night. Emma stated she did not want her mother involved in her care & did not want her at her meetings. Advised Emma not to speak to her mother the phone for a while to give her & her mum some breathing space in order to resolve the relationship. Emma agreed. Also discussed distraction techniques & what was used for her. Emma stated that whilst these were on some occasions these helped her on this occasion. Child protection drug administered with settling effect @ this point.	
14/9/05	Met Emma. She has been out with Mum. She is now at home at night. She is now at home at night. She is now at home at night.	
	Emma has been at home at night. She is now at home at night. She is now at home at night.	
	Spent some time going over the details of the case. She is very accepting of her situation.	

DATE	FORMATIVE EVALUATION	SIGNATURE/ DESIGNATION
	14/9 - Emma can go on page 3 after returning. If we have spoken to her. - I have left an invitation with her. The following searching task will need to be completed. - Staff need to let her know on a "good to know" basis of any important happenings. There needs to be a period where Emma is isolated from her and not correct. It is to be done. The needs to be that it is a consequence. The car was not in the house. It is to be done. She will be informed of any other significant event. 14/9 - Emma can go on page 3 after returning. If we have spoken to her. - I have left an invitation with her. The following searching task will need to be completed. - Staff need to let her know on a "good to know" basis of any important happenings.	
14-9-08 Nursing 1930hrs	Emma is marked soiled for the rest of today although become a bit of a & borsorous upon the arrival of a new patient. Had dinner & shortly after left on peer walk with Sui & N.H. Total model contact maintained throughout the day.	
15/9/05 5-45am	Fairly settled around the center^{center} with this evening. Spending time with peers in tv room. Had snack and returned to tv room. Whilst in tv room Emma pulled down fellow peers T.M's shorts. Stated this was a joke and "only a laugh" but told by staff that behaviour was unacceptable. Disgruntled about same and annoyed by staff, stated she wanted to phone her mum but told "no" as after 10-30pm and bedtime. Eventually settled and slept from around midnight	S/N
15/9	CT result - heard Noonan at	

GREATER GLASGOW NHS BOARD - PRIMARY CARE DIVISION

FORMATIVE EVALUATION
NOT PROGRESS NOTES

UNIT No.

PATIENTS NAME EMMA LINDSAY

DATE OF BIRTH 26.8.90

WARD/DEPARTMENT ADU.

DATE	FORMATIVE EVALUATION	SIGNATURE/DESIGNATION
16.9.05 16 ⁰⁰ hrs WEDNESDAY	met with Emma this afternoon to discuss events of yesterday evening. Emma informed me that all the young people in the P.V. room had been 'faking around'. Emma says she became 'manic' and pulled fellow peer c.m.c.p's trousers down. We discussed the fact that this behaviour was very inappropriate and of a very serious nature. Emma acknowledged this and appeared remorseful, stating that she would modify her behaviour in future.	
19.30/10	Met with Emma today as her Tidal nurse. Emma has had an "ok" day. Spending lots of time in fellow peers (S.C.) company. Tiding up the garden with staff. Attended groups today although she seemed quite angry in Solihull group this afternoon. Still not speaking to her mum. Brother visited this evening.	RMD
16/9/05 0630	Emma has had a fairly settled evening. Spending time in company of peers. A staff had snapt. returned to bed at 10.40 pm. Emma approached myself at 11.00pm stating that she felt "crap" spoke about her mum so that she won't be going back. to stay with her when she leaves the ward, started to get quite tearful, suggested to Emma that she should try and make things better for her self, taking some responsibility for her actions and noting that she should phone her mum. Emma agreed to this, settled soon after and appeared to sleep well.	S/N
15/9/05	SPR Review:	
MEDICAL:	Feeling ok - remains angry i mg - doesn't want to go home at weekend or for mg to come to ward meetings - saw brother last night, but he can't take her out @ w/e as he is on a	

DATE	FORMATIVE EVALUATION	SIGNATURE/ DESIGNATION
16/9/05	says also she doesn't want to be discharged to home Feels her mother doesn't believe she has an illness → felt v. angry @ this Self-harmed - sup^r cuts/scratches to L arm - last night. Did not req. sutures. Did this to give "clarity" to her thinking re-her mg Does not want to die Feels hopeful about the future - has plans for weekend. Asking for unaccompanied leave from the ward to go to Byres Road. <u>MSE:</u> casual dress hair in pigtails good eye contact + rapport co-operative ± i/v sup^r scratches on arm (L) no signs of agitation/distress speech n rate + volume mood euthymic ± reactive affect ± suicidal / homicidal ideation Nil psychotic ^{of} FTD no abn percepⁿs cogn - intact insight - has understanding of diagnosis Agreeable to R_x plan. <u>Imp:</u> settled currently Gave permission to contact mg + inform of decision not to come home at weekend. <u>Plan</u> allow 1 hr unaccompanied leave at w/e to locale ↑ at nurses discretion if settled TL to mg - message left to mg's partner	

GREATER GLASGOW NHS BOARD - PRIMARY CARE DIVISION

FORMATIVE EVALUATION ~~NOT~~ NOTES

PATIENTS NAME ^{Mr} Emma ^{by} Lindsay

UNIT No.

DATE OF BIRTH

WARD/DEPARTMENT

SIGNATURE/DESIGNATION

DATE	FORMATIVE EVALUATION	SIGNATURE/DESIGNATION
16/09/05 Nursing 19:30hrs	Met with Emma as to hotel model nurse today. Emma appeared settled during the day. However, at 1600hrs Emma appeared low in mood & stated she had spoke to her mum & her mum had stated she couldn't care less about her case & didn't care how she lived. Emma able to discuss this in a mature fashion & could see that perhaps her mum was hurt & this was why she had responded to him this way. Emma & I discussed possibility of her writing a letter to her mum & Emma stated she would give this some consideration. However, Emma also stated that she had a 'nigger' for her mum & made her mum ill. Expended to Emma that her mums illness belonged to her & was unchangeable & Emma & Emma shouldn't blame herself for the same. Some Accepted.	
17.9.05 04:00	Emma has spent a settled evening interacting well with peers & not appearing preoccupied or distressed. She slept well. On one occasion, Emma was observed to be inappropriate to peer SK, mocking his stained clothing & making sexual innuendoes. She was challenged about this.	S/N
17/9/05 2pm	Emma has had an active time. She was following SC around the unit. Appears generally in good spirits. Went out to Mansions and indicated she was tired when she came back. Helped move furniture into putting room.	
1630	Emma seems to go down a bit. Very fidgety. Following S about. Didn't eat very much. Spoke to her with LM and she seemed OK.	NA
1930	Emma very involved with the girls. She didn't want to sit down and discuss her day with me in her room, but informed me her day was fine. She enjoyed her visit to Mansions. She is still a bit flat compared to her afternoon "high". Looks tired. Enjoying LM & SC company.	11 LHM
18.9.05 05:00	Emma was busy, helping peers dye their hair & then settled down for a video which she appeared to enjoy. She had difficulty sleeping after retiring at 12:15, complaining of difficult thoughts in her head.	

DATE	FORMATIVE EVALUATION	SIGNATURE/ DESIGNATION
18/8/05 18:30pm	She eventually settled to sleep around 3 am. Emma was up early this morning interacting with fellow peers & attending to her personal hygiene & dietary needs. She remained settled & left the ward after lunch to go on outing to cinema, not back at time of leaving.	S/N.
19.9.05 05:30	Emma has had a settled evening, hanging out with peers. She was sick briefly outside, but did not appear overly distressed & the episode soon passed. She slept well.	S/N.
18:30hrs	Spent most of the day in company of peers. Mood fluctuated today & all appeared quite behavioural. Mimicking the behaviours of other peers in the unit. Had an aggressive outburst with staff when asked to leave the games room to join a therapy group. Emma then burst into the group room shouting and swearing. She then got up and left. Emma then spent the next 40 min pacing up and down the unit, refusing to speak with any staff who wanted to offer any support. Emma's behaviour appeared quite hostile in nature.	RMS.
20/9/05	Emma rang her mum this evening but mum put down the phone on her to which Emma reacted with verbal and physical aggression, knocking over furniture in room. Following this however Emma settled, quickly and remained overall settled. Spending time with peers and attending to her laundry. Stated that she wanted to apologise to dayshift staff for all earlier outburst. Emma was slow to return to bed and rose again at approx 11:30pm to request a glass of water. After which Emma returned to bed and appears to have slept well overnight.	EMM
20th/05 10am	Team Meeting - To have appointment with guidance teacher at own school. Emergency social work meeting to be arranged due to discharge date on October 14th but Emma is refusing to go home, to look at social skills and role play around Emma's behaviour. To continue to attend physio. Must attend time table activities, not to do fun activities, and must catch up with work feedback.	mm
19/9/05 MEDICAL	Feedback given to Emma School - "doesn't like it" - will try to go more often. Acknowledged that voice may improve & distraction of school.	

FORMATIVE EVALUATION

PATIENTS NAME Emma Lindsay

UNIT No.

DATE OF BIRTH

WARD/DEPARTMENT

SIGNATURE/
DESIGNATION

DATE	FORMATIVE EVALUATION	SIGNATURE/ DESIGNATION
20/9/05	Agrees to meeting & Guidance teacher - Colin - new teacher to house & school Has phoned mum - however mum hung up the phone on her. says she doesn't care about this anymore wants to be placed in care somewhere outside Ayrshire - "as far away from mum as possible" Brother - lives & his friend in Shiring. Coming to visit tonight Says she has stayed with him a lot. Would like to go there on pass this weekend Had unaccompanied pass at w/e to Byres Road. Would like to have this increased (has had 1hr so far) Self-harm - sup^r - 2/7 ago when was feeling low NOT since. NI suicidal One episode when lost temper & a member of nursing staff who had put limits on her behaviour. <u>MSE</u> casually + approp. dressed full make up somewhat sullen during ill - but observed to be bright + interactive & peers Good eye contact + Moderate rapport ° signs distress / agitation mood - subj low obj ?sl. low Reactive affect <u>No</u> suicidal / homicidal ideation	

DATE	FORMATIVE EVALUATION	SIGNATURE/ DESIGNATION
19/05	Nil psychotic Cogn - not formally assessed insight - Agrees = Dx + current Rx plan.	
	Plan - contact social work asap.	
20/9/05 3pm	↓ message left for: W - W - T	Spr
	TTC to W - has made an urgent referral to social work - will phone again this week. S.W team need this in writing from	
		Spr
7pm	Met with Emma as her Tiden nurse for the day. Emma reported that she had voices in her head telling her that staff were out to get her and she shouldn't speak to us. However she did not appear pre-occupied with auditory auditory hallucinations. Spending most of her day in company of fellow peer S.C. Needing limits and boundaries set.	RUN
21/9/05 NURSING 0530hrs	Emma spent evening in company of peers, in games room. Limit set on length of time to be spent outside in garden with peers and this was accepted. Initially slow to settle into bed however appears to have slept through the night. Noted that Emma has gone to sleep with her door wide open for past two nights. Emma states that she feels claustrophobic when closed.	MN
21/9/05	Meeting c. 11 - summary of care given + plan Karen to meet Emma on her own She will arrange a meeting with social workers - I will attend.	Spr

TEAM MEETING
KELVIN TEAM

(NAME) Emma Lindsay
(DATE) 20.09.05

Nursing Report

Reports feeling low in mood – interacting well with peers and objectively appears bright.
Requires a lot of boundaries and limit setting.
Has fallen out with Mum – says she feels unsafe with the door.

Medical Report

Very settled.
Mental state remains stable.
Had an argument with Mum on Friday.
Had arranged for pass herself locally at weekend.
Some superficial cutting as self-harm at the weekend.
Phoned Mum – reports Mum & Mary as both being very negative about Emma.

Current Psychotropic Medication and Working Diagnosis

Psychology Report

TEAM MEETING
KELVIN TEAM

(NAME) Emma Lindsay
(DATE) 20.09.05

Dietician Report

Occupational Therapy Report

Liaise with SPR
Engaging in some bullying behaviour.
Poor social skills.

Other Disciplines – Physio, Etc

School Report

Attendance – same.

Social Work Report/Family Work

Group Work Report

Poor social skills evident in group.

Risk Assessment

Decision and Pass Arrangements

- [] to ask SW to convene emergency meeting to look at placement since she is refusing to go home.
- Nicole will look at social skills and do some work around this.
- Discharge set for 14.10.05.
- Continue attendance at physio.
- Set appointment with Guidance Teacher at own school.
- Put sanctions in place so that if she refuses school she is denied fun activity.

WARD ROUND

KEY POINTS AND ISSUES:

- Emma reports that she feels low in mood most of the time. However objectively she seems quite bright and appears to interact very well with her peers within the unit.
- x Emma also reports that she experiences auditory hallucinations although there is no visible evidence of pre-occupation with voices.
- x Always visible around the ward with fellow peer S.C. trying to talk him into doing activities she herself should be doing.
- x Requires lots of boundaries + limit setting.
- x Was spoken to regarding an incident with when she pulled down his trousers in T.V. room in front of girls.
- x ~~Continues~~ ^{seems} to have similar problems as other young people in the unit. i.e. falling out with mum. can't keep herself safe when front door is open.

RECOMMENDATIONS:

- x Continues to struggle with healthy food options.

Encourage to go out on pass.

Document mood + behaviour

Encourage attendance in all groups + school.

Encourage healthy eating.

GREATER GLASGOW NHS BOARD - PRIMARY CARE DIVISION

FORMATIVE EVALUATION

PATIENTS NAME Emma Lindsay

UNIT No. T/1778682/1

DATE OF BIRTH 26.08.90 WARD/DEPARTMENT ADU

DATE	FORMATIVE EVALUATION	SIGNATURE/DESIGNATION
21/9/05 Nursing 17:00	Met with Emma on three occasions today as her tidal model nurse. Emma reported she had not a bad day. Emma attended Discovery group and participated well. Emma's mood has dipped slightly but has ^{now} responded well with support. Emma has mixed well with peers and staff and showed no signs of management difficulties.	
22/9/05 NURSING 04:00hrs	Emma has spent majority of evening in company of peers in the games room - chatty and good humoured. Appropriate interaction with staff. Emma was late to settle and became disgruntled towards LM due to her light being on. However managed to settle and appears to have slept through the night.	
22/9/05 Nursing 20:40	Emma had a really good day. Emma responded well considering Wave activity. Emma interacted well with peers & staff and no management problems were evident. Emma spent most of the day in T.V. Room with the rest of her peers.	
23/9/05 06:00 Nursing	Emma socialising well with peers this evening. Attended for snack and settled to bed at 1130pm. Nil problems to note this evening.	RMN
23/9/05 18:00	Emma has had a settled day with regards to her mood and behaviour. Interacting well with staff and peers and engaging when approached by allocated worker. Emma has been bright and pleasant throughout the day and at time of writing is on unit outing to cinema and bowling.	
23.9.05	No complaints offered on approach. Attended outing. No problems evident.	
24.9.5 06:50hrs	Mood and behaviour remained settled and appropriate in the evening. Retired to bed at midnight, slept well overnight.	
24/9/5 Nursing 10:00	Emma spent the majority of her day in the company of peers interacting well with peers throughout the day. Approached staff on several occasions complaining of nausea and apparent vomiting, although no evidence observed. Encouraged to maintain light diet and maintain hydration, but observed eating chocolate and soft drinks. Counselled regarding this and states that she suffers condition hallucinations to vomit after eating, provided with support at this time and appears settled at time of writing.	

DATE	FORMATIVE EVALUATION	SIGNATURE/ DESIGNATION
25/9/05 Nursing 07 ⁰⁰	Emma spent most of the evening in the games room with peers. Attended for snack and settled to bed at 11.50pm. Appears to have slept overnight. — (	
25.9.05 15 ³⁰ hrs Nursing	Emma continues to struggle with managing diet. states she feels like 'crap'. spending time in company of peer (S.C.), complaining of being 'bored' however brightened up at prospect of spending some time off the unit. —	
26/9/05 Nursing 0630	Emma watched film with peers before retiring to bed at 11pm. Complaining of feeling sick whilst trying to sleep however managed to fall over to sleep around 12 midnight. Appears to have slept overnight. — (	RMN
1930	Emma did not want to meet today for Tidal Model review as staff we will argue with stuff what is into. Still she has struggled with her Care Plan today. Did not want to go on organised trip with today. —	11
27/9/05 06.50hrs	Initially observed to be bright during the evening interacting well, attended supper. Noted to be disappointed after games room was locked at bed time. At 10.45pm Emma was found to have superficially cut her left arm. Emma cleaned this herself, no dressing was required. Emma claimed she self harmed, using a razor. Emma at present is refusing to hand in the blade from the razor. Emma then at 11.30hrs stated she had been hearing 'them' voices telling her to kill herself. Requested PRN, nil prescribed as same discontinued. Emma sat in bed and noted to stare into space. Reluctant to voice any further details. Staff put on relaxation CD to distract Emma from voices. Gave reassurance that a staff member would be in the corridor at all times should she feel unsafe. Emma appeared to accept this. Noted to be asleep by 1am. Note that Emma has requested her bedroom door be left open every night. —	90
27/9/05	TEAM MEETING → (1) Appt. with guidance teacher in progress. (2) CAMHS team in east ayrshire, and social work have been contacted regarding planned discharge. (3) Family meeting planned for Thursday 29/9. (4) OT still to have regarding rehab (5) Diana Forsythe to provide feedback. —	RMN

FORMATIVE EVALUATION

PATIENTS NAME Emma Lindsay

UNIT No. T/1778682/1

DATE OF BIRTH 26-08-90 WARD/DEPARTMENT A.D.U.

DATE	FORMATIVE EVALUATION	SIGNATURE/DESIGNATION
28/9/05 MEDICAL	SPR Review "feeling crap" today Thinks that voices are a bit worse than usual over past week low in mood worried about future - ie what will happen when she is discharged self harmed last night -> says she can't remember what happened - however was able to let me know that she had been prevented from continuing this. Had wanted "clarity" of thinking - didn't stop get this as was stopped Has had continuing thoughts of wanting to self harm (arms + legs) but has managed not to respond to this Still no contact w/ Mum - continues to feel angry - doesn't want contact Says she will think about coming to the family meeting on Thursday Re-school - attendance poor - encouraged again to attend & reminded of d/jw Dr Gardiner on this subject (ie if not attending then Discharge will be brought forward). continues to want to go to college instead of school & advised to discuss this with school + guidance teacher. Re Pass - wants unaccompanied MSE to Brazil. (No pass over w/t due to weather) casually + approp. dressed self care good sullen in demeanour good eye contact + moderate rapport signs of agitation / distress calm + appropriate Speech - Spontaneous, normal rate + volume.	

Sleep
appetite
conc ↓
energy

DATE	FORMATIVE EVALUATION	SIGNATURE/ DESIGNATION
27/9/05	Mood Subj low Obj - low - reactive affect Thoughts of self harm, <u>not</u> suicidal ^{of} FTB ° abn beliefs in psychotc cogn ✓ insight - fairly good. knows groundiffs - agrees to help from nursing staff. etc. <u>Plan</u> 1/ inform nursing staff of current thoughts of self harm - ↑ distraction + monitor MSE. - Nursing staff to inform if any concerns 2/ TIC to Karen McMahon ✓ - she will phone SW to expedite referral & will relay info back to ward. 3/ TIC to Mrs Lindsay re family meeting → did not know about family mtg this week - not sure if she + Mary can make it. Remains angry c Emma. Advised the need for mtg to discuss management. Agrees to attend if possible - will confirm tomorrow morning.	
27/9/05	Emma states that she has felt 'crap' today. Has refused any food and fluid intake has also been low. Managed a little to eat at dinner time. Emma states that she is hearing voices which tell her not to eat, derogatory and negative comments to Emma. Encouraged to maintain levels of hydration and dietary intake despite auditory hallucinations and discussed importance of same and use of distraction techniques. Emma utilized distraction with good effect. Emma has spent majority of day in company of peers and in the games room. Emma also attended walking group which she appears to have enjoyed, interacting well with peers. Settled at time of writing.	

Emma

MEETING

EMMMA LINDSAY

TEAM

27TH SEPTEMBER, 2005

NG REPORT

stition remains same. Several complaints of physical ill-health. No evidence of vomiting. Always
ens up soon after making complaint. superficial self-harm yesterday – said it was in response to voices.
limits re behaviour. spending time with peer SC. Often refuses activities if SC will not be involved too
pling with healthy eating plan.

AL REPORT

al state settled. No increase in complaints re voices. Mood stable but can vary with events on the ward.
, nurse from CAMHS. Referral sent to area SW Team re accommodation.

ENT PSYCHOTROPIC MEDICATION AND WORKING DIAGNOSIS

HOLOGY REPORT

essed concerns re likelihood of move away from family home. ?could support be put into family house.

TEAM MEETING

KELVIN TEAM

EMMMA LINDSAY

27TH SEPTEMBER, 2005

DIETITIAN REPORT

OCCUPATIONAL THERAPY REPORT

OTHER DISCIPLINES – PHYSIO, ETC.

SCHOOL REPORT

Sometimes refusing to come to class. Often refuses to work in classroom and works in open area. More often fails to attend school than not.

SOCIAL WORK /FAMILY WORK REPORT

GROUP WORK REPORT

RISK ASSESSMENT

DECISIONS AND PASS ARRANGEMENTS

- OT to liaise with re rehabilitation.
- SW to explore.
- Appoint with guidance teacher.
- see re limit setting.

WARD ROUND

KEY POINTS AND ISSUES:

- little change from last week. presentation similar.
- Again sporadically complaining of voices when not in company of peers.
- On a few occasions complained of feeling unwell physically however always seemed to brighten after initial statement. stated she had vomited on one occasion no evidence of same.
- self harmed superficially with razor on mon evening complained of having voices at this time. would not elaborate. Listened to music for distraction.
- states she feels 'crap'
- Spending most time in company of peers. (s.c.) in particular. Has required limits set re boundaries and behaviour.
- Continues to struggle with healthy eating
- Has enjoyed time out with staff and peers eg cinema outing. Declined eating in men.
- ? no contact with mum since 20th. wants to be placed in care.

RECOMMENDATIONS:

Encourage compliance with time table and eating plan.
Monitor health - physically
Assess for auditory hallucinations.

GREATER GLASGOW NHS BOARD - PRIMARY CARE DIVISION

MDT NOTES
FORMATIVE EVALUATION

UNIT No. T/177868211

PATIENTS NAME EMMA LINDSAY

DATE OF BIRTH 26/08/90

WARD/DEPARTMENT

ADOLESCENT UNIT

SIGNATURE/
DESIGNATION

DATE	FORMATIVE EVALUATION - MDT NOTES	SIGNATURE/ DESIGNATION
28/9/05 07 ²⁰ hrs	Keeping a low profile on the unit tonight, avoiding staff although still spending time with her peers. During checks at 22-30hrs found to have inflicted various superficial cuts to left arm using a piece of glass. Attended treatment room and cleaned arms and dressing applied. Emma remained low in mood and on next check found to have put a ligature around her neck. Gave this to staff when asked. States her mood is very low and feels hopeless about her situation. Eventually settled and slept at midnight.	S/W
28/9/05	SpR Review:	
MEDICAL	Self harmed last night - sup ^f cuts to arms - in room - found by staff ligature round neck - not tightened - but says she wanted to die Upset afterwards. Slept after staff reassured her says "voices" bad at present Mood low over past few days - feels v. worried about her future + what is going to happen feels that no one is concerned with how she feels. Some continuing thoughts of self harm / wanting to die - No plans. However able to talk about what she would like to do. Mood low - says this always happens to her - can feel good for 1/12, then bad for 3/12. Explained need for finding an alternative method of coping rather than self harm. Emma able to understand this + seemed to take this on board. Agreed that this had been her way of coping in past. Agreed to trying to look at different ways to cope. Distraction imp - discussed ways of keeping busy Finding school hard - ∴ go to class	

DATE	FORMATIVE EVALUATION	SIGNATURE/ DESIGNATION
28/9/05	+ stay for short period - go for walk ✓ -> come back to class [D/W teachers → agreeable to this] Emma also finds enjoyment spending time & peers / PS2 - Described the need for ability to be able to cope in times when peers not around. <u>MSE:</u> self care ✓ good eye contact + rapport fearful initially - then more able to smile / joke ✓ no signs of agitation / distress Speech N rate + vol mood subj - low obj - low, but & reactive affect Some suicidal ideation, but no actual plans All psychotic cogn grossly normal insight - Partial - knows she has difficulties + agreed to help & these <u>Imp</u> Mood low (no biological fx of depression) Recent ↑ self harming behaviour ? in response to uncertainty over home situation / discharge * Risk of impulsive self harm. <u>Plan</u> - monitor MSE - please could nursing staff have 1 or more 1 to 1 sessions daily & her - encourage ward activities + school (as above) - Emma to take some responsibility for keeping self safe - ie approaching staff when distressed. - Emma agrees - JAT on 4/10/05 @ 9.45am - DF to attend	

FORMATIVE EVALUATION

UNIT No. T/1778682/1

PATIENTS NAME Emma Lindsay.

DATE OF BIRTH 26/8/90

WARD/DEPARTMENT ADC

SIGNATURE/DESIGNATION

DATE	FORMATIVE EVALUATION	SIGNATURE/DESIGNATION
28/9/05	Has appeared low in mood today. Continues to have some problems at meal times and is unable to eat. Emma spoke with doctor last night. Self harm. Has appeared bright and chatty while engaging with peers. No management problems noted.	
29/9/05 otao	Emma's mood appeared low at on set of shift but did not quickly spend time with peers. SC. came down for snack & did manage no problems. Emma's mood slightly dipped prior to bed time advised to have a shower to help wind down. Emma did this & was advised to write in her diary to help distract her thoughts. did manage this and appeared to have slept over night.	
29.9.05 Medical	Asked to speak with me. Says she's feeling "crap". Says her mood is really low & that she's not getting any spells of elevated mood like she used to. Says the voices are worse than ever. Says she hasn't eaten at all well for 2 weeks. The voices tell her she'll get fat & that she should induce vomiting after eating. Says she self harmed 2/7 ago - numerous superficial wounds to L arm noted. Denies suicidal. Denies that her lowered mood is in response to the difficulties with her mum. MSE Self care excellent. Hair styled & make up applied. Able to establish good rapport with excellent eye contact. mood - subjectively low. Subjectively grumpy and reactive. Talks readily, articulately and able to be reciprocal. Thoughts. NO FTIS. NOT psychotic. No suicidal ideation. Imp. Mood grumpy & dissatisfied. In response to problems at work. mum and approaching discharge. Asking for prn medication. Declined & spoke about previous discussion re.	

DATE	FORMATIVE EVALUATION	SIGNATURE/ DESIGNATION
	illness VS personality. Discussed my expectation that pm medicare wouldn't lay her current situation.	
30/9/05 06:00 Nursing	Accepting of turn Emma appeared bright in mood this evening around unit. Spent time in TV room with fellow peers. Retired to bed at 23:30pm appears to have slept well over night.	slv
30.9.05 Medical	N/A Joe Campbell reported to me that Emma has used abusive language to him on several occasions this afternoon when he has reminded her to attend school. IRI form completed by slv Discussed the issue with Emma. I told her that the verbal abuse of any staff was not acceptable + that I expected her to stop this behaviour + to apologize. Informed her I would let Dr Gardner know of this issue. Emma handled this discussion well + said she recognized she'd been out of order.	N
30/9/05 Med	Upset + unsure at nurse Spent some time discussing this Emma is slightful + apologetic May have pass to Brother if it can be arranged	
18.05.05	Emma has had a difficult day feeling low in mood, appearing fearful at times. Didn't want to go to school, and didn't respond well to limits + boundaries being set. Was seen punching doors and abusive language used towards staff. Seemed to require ++ attention around mealtimes. Seemed more settled after evening dinner. Contact made with mum and seemed to have made up.	RNN
11/10/05 06:30	Emma has been very settled this evening spending time with peers in music room, retired to bed at 11:15 with out any prompting, no management problems noted slept over night.	slv
01/10/05 19:10hrs	Enjoyed A LONG LIE IN TODAY AS IT IS THE WEEKEND, SPENT EARLY PART OF DAY LOOKING QUITE FLAT AND WITHDRAWN, BUT MOOD APPEARS TO HAVE LIFTED THROUGHOUT THE DAY, SOCIALISING WITH PEERS AS TIME OF WRITING.	slv
19:30	Emma enjoyed a trip out with peers & staff to a local cafe mid afternoon. She had to be coaxed & cajoled but did consent.	slv
21/10/05 06:00	Emma has been in good spirits this evening, mood brighter. Spoke about phone call to mum. Stated that she was glad they have cleared the court	slv

slv

slv

GREATER GLASGOW NHS BOARD - PRIMARY CARE DIVISION

FORMATIVE EVALUATION

UNIT No. T/177868211

PATIENTS NAME EMMA LYNDSEY

DATE OF BIRTH 26/8/90

WARD/DEPARTMENT ARD

SIGNATURE/DESIGNATION

DATE	FORMATIVE EVALUATION	SIGNATURE/DESIGNATION
2/10/05 obco	air, and may go home for a few hours next weekend, spent time with other peers, no management problems noted, retreat to bed at 1am with no prompting and appeared to have slept over night	SN
2/10/05 19.10.5	Spoke with Emma a few times today and she reported no problems. Was a bit bored this morning but mood improved when she was in the games room with her peers. Being assigned Emma as my Tidal patient for the day there are no problems to report.	W N/S
3/10/05 obco	Emma has been settled this evening spent time with peers in music room and watched film on TV. mood bright retreat to bed at 10.30pm and appeared to have slept over night	W N/S
3/10/05	SPR + SNL	
MEDICAL	Peer alleged that Emma & SC had been groping each other in an inappropriate manner. Emma was asked about this -> says she & Scott are friends, nothing more. Denies any inappropriate behaviour. Told clearly that any sexual contact between young people on the ward was strictly against ward policy and would not be tolerated. Feeling a lot better - brighter in mood, distracting self/keeping busy. Spoke to me over W/E. Agreeing to meet Guidance Teacher and me (at family meeting on Friday.) Staff will continue to monitor closely. <u>NB</u> T/C to Social work - message left. No response as yet.	W N/S

DATE	FORMATIVE EVALUATION	SIGNATURE/ DESIGNATION
3/10/05 19.30	Met with Emma on a few occasions today. Emma states that her mood is better than it has been over the past couple of days. Spent time interacting with peers. Continues to have difficulties around eating, requiring prompting by staff to eat at meal times. Continues to express hearing voices, telling her to make herself vomit, and also states that she feels at present self-harming is giving her a release when she feels stressed. States that she is unable to use distraction at present. Spoken to by Dr Forsyth and staff nurse / McCombe re being different from when peer S.C. appeared to accept same however noted to be going fellow peers who made the story up about her and peer S.C. later on in the evening. Otherwise, Emma has had a settled day spending time in the TV room.	RMN
4/10/05 NURSING NIGHT SHIFT	Emma spent time in the company of peers this evening, mood appeared settled, chatting appropriately in the room. Shortly before bed-time, Emma stated that she is very annoyed about the discussion today re. her overfamiliarity with peer S.C. She denies any inappropriate behaviour and feels very victimised. She wants to know who reported this to staff as she feels somebody 'is wanting to get back at her' about something. Emma also feels she will lose friendships with fellow peers M.H. and S.C. through this and that trust will also be lost between herself and staff. Emma responded well to reassurance however and accepted praise that she had managed to control her anger. Emma then spent time tidying her room and reading a magazine. Emma was late to settle however appears to have slept well through the night.	
4/10/05	Team meeting - Work to continue with mum and Dr Gardiner. Possibility of commencing quetiapine: at a low dose (Spil McCormack) to discuss carboxephon & sexual health with Emma. To have home visits. Feedback N. McCombe.	RMN
4/10/05	JAT Meeting - Ayr Academy School unable to decide on support package until Emma's accommodation issues are settled. School willing to have Emma back. Advised will need ++ support + gradual	

PATIENTS NAME EMMA LINDSAY

DATE OF BIRTH 26/8/90

WARD/DEPARTMENT ADU

DATE	FORMATIVE EVALUATION	SIGNATURE/DESIGNATION
4/10/05	RE-introduction to school. School covered re peer issues + will try to re-introduce her gradually. Meeting to Guidance Teacher arranged for Thursday 6th Oct at 2pm. TIC from - S.W. → allocated. Worker will be explained about discharge date. Meeting on ward set up for Thursday am to - nursing staff to attend. Above feedback to Emma	(Mrs Byers)
4/10/05 20:00	Met with Emma a couple of times today. Emma states her day has been 'alright'. Didn't attend school due to sickness. She felt tired. Hadn't had a good diet or fluid intake today. Also reports vomiting today after eating. States voices are very loud and getting worse, making it difficult for her to cope. States she can feel herself "slipping" again. States she occasionally feels stressed, and the only time she isn't stressed is when friends are around her. Continues to find distraction very difficult. Spoke about way of Emma moving forward and coping effectively. Emma stated that she finds it difficult to talk about her feelings, and also stated that "the more it's over, the more she is able to cover it up" and appear as if nothing's wrong. At time of writing report Emma is settled in mood. Noted to be playing fighting with peer SC. Asked about same.	U.S.P.K.

DATE	FORMATIVE EVALUATION	SIGNATURE/ DESIGNATION
5/10/05 NIGHT SHIFT	Emma appeared settled at onset of shift, spending time with peers, attended for snack and spent time in games room, quite loud at times but amenable. Retired to bed at ~10.40pm, read a magazine stating she was not tired enough to sleep. At approx 11.45pm Emma was found to have self harmed using a razor blade, to her left arm. Emma was quite fearful but stated she did not wish to talk about precursors to this incident. Wound was cleansed, some superficial scratches to lower left arm and 5/6 deeper lacerations which required ^{energy} ten steri strips and a non adhesive dressing. Emma stated that there had not been a specific incident which had caused her to self harm however she has been feeling increasingly low and 'unable to cope' at the moment. She chose to read her book as distraction and read up until approx 0230hrs when she fell asleep and appears to have slept IR1 completed.	11
5.10.05 Medical	Reviewed Sore L leg. Thinks pain is caused by kicking at the wall. 9/10 pain down front of shin • can't explain why she has pain on her shin after kicking out 9/10 pain down length of shin - worse on flexing her knee 9/10 Shin - red - No bruising / swelling - Muscular tenderness at upper shin - Full ROM at knee & ankle - Major soft tissue injury NO evidence - Simple analgesia if required - NO other treatment necessary	1
5/10/05	Had been seen (+ a patient who made a complaint verbally) to saying abusive things to a patient with content around the pt's mental state. Emma owned up to it. She will make amends + apologise. I also told her that if this happens again I will discharge her at once. (In my absence another consultant will do this) Daryn + I spent some time with Emma discussing how to poor verbal feedback. Emma will spend time with nurses about how she would feel if she was the victim. Emma's behavior was labelled as bullying and our "Zero tolerance" of bullying was reiterated.	

TEAM MEETING
KELVIN TEAM

EMMA LINDSAY
04.10.05

Nursing Report

Mood fluctuating.. One incident of self harm by cutting. One attempt to place ligature round her neck.
Brighter at weekend. Resuming contact with mum.
Still complaining of hearing voices saying she's fat.
Requires prompting to stick to healthy diet.
Felt to have an inappropriate relationship with peer SC. Feels victimised because staff have drawn this to her attention.

Medical Report

Doing well.
No evidence of deterioration in mental state.
Dr Gardiner would be prepared to consider a low dose of antipsychotic to treat Emma's "voices."

Current Psychotropic Medication and Working Diagnosis

Psychology Report

Dietician Report

Occupational Therapy Report

undertaking a social skills assessment some of which will be community based.

Other Disciplines – Physio, Etc

School Report

Only able to stay in class for short spells of time.
JAT meeting taking place today at Emma's school.

Social Work Report/Family Work

Mum is not encouraging Emma to return home despite Emma saying she is prepared to do so. Social work are involved.

Group Work Report

Risk Assessment

Decision and Pass Arrangements

- May have pass as much as she requests at weekend.
- Discharge planned for 14.10.05
- Advice re: contraception to be offered by

EMMA LINDSAY

WARD ROUND

4/10/05

KEY POINTS AND ISSUES:

- Emma's mood has continued to fluctuate over the week
 - 1 incident of self harm (28/9) cuts to left arm
 - later found with ligature around neck which she then gave to staff
 - 1 incident of aggressive behaviour (30/9) verbally abusive to staff and punching doors. Later apologised and showed insight into this being inappropriate.
 - Mood lifted over weekend, more settled in presentation
 - Coaxed into joining peers on trip to a local cafe @ weekend
 - Phone call to mum (30/9) appears to have resolved conflict.
- Continues to complain of hearing voices - derogatory, tell her that she is fat, to induce vomiting after meals
 - Has required prompting and support at meal times, which she responds to.
 - Has also been discouraged from indulging in chocolate.
- Continues to require prompting to attend timetabled activities + school
- Spoken to about over-familiarity with S.C. Denies this. Feels victimised
- Emma's mood noted to react to specific incidents and Emma states that she is also very sensitive to the mood of others

RECOMMENDATIONS:

- Monitor mental state, mood + behaviour for any signs of auditory hallucinations.
- Continue to encourage involvement with healthy eating plan.
 - Involve Emma in snack preparation?
- Pass home @ weekend?
- Encourage use of distraction + relaxation.

GREATER GLASGOW NHS BOARD - PRIMARY CARE DIVISION

FORMATIVE EVALUATION

UNIT No. T/1778682/1

PATIENTS NAME EMMA LINDSAY

DATE OF BIRTH 26/8/90

WARD/DEPARTMENT A.D.U

DATE	FORMATIVE EVALUATION	SIGNATURE/DESIGNATION
5/10/05 18-25	Met with Emma a couple of times today. Emma has been flat in mood throughout the day, spending limited time with peers. Emma states her mood hasn't been great today. Required prompting to go to school, however only managed short periods. States that she has been self-induced vomiting today. Also stated that she was about to self-harm, but managed to stop herself and handed in a razor. Emma spoke about incident earlier on in the day when she shouted abuse at a fellow patient. Stated she was very sorry for this and will apologise to patient for same. Also spoke to Emma today about ways of challenging certain behaviours, and also spoke about previous experiences that have perhaps contributed to the way Emma feels about certain situations. This is to be explored more in individual sessions. At time of writing report Emma remained quite low in mood.	KMM
6/10/05 NURSING	Emma remained quite flat in mood this evening, reporting that she was feeling low again. Emma responded well to staff reassurance however and appeared more mature in acknowledging the reasons why this she was feeling low, able to speak more honestly about her feelings. Spent some time in the company of peers in the games room, retired to her bedroom at approx 10.30pm. Emma stated that she still felt low in mood and nervous, encouraged to make her bedroom comfortable and remained low but settled into bed thereafter. Appears to have fallen asleep at approx 11.30pm and has slept through the night.	SNW
12:30	Discharge planning meeting: present Dr (CAMHS), Dr S/N. (S.W.) asked what SW position is come Emma's projected discharge date on Fri 14 Oct '05. Dr Gardiner expressed concern that Emma may deteriorate if kept longer than necessary, though assured all present Emma would not be 'turned out' prematurely. reported that Emma's presentation was very different & improved on meeting with her 2 wks ago, this included the ability to reconceptualize voices as interior thoughts though she questioned whether Emma's	

DATE	FORMATIVE EVALUATION	SIGNATURE/ DESIGNATION
1	behaviour could be maintained at home. A discussion of Emma's family circumstances took place, & the limited options available. Plan: - nursing staff to speak to Emma re. home visit on Sat. - To be collected from unit & taken home by Marilyn Miller for first contact with Emma & Emma's mother, Alicia. (11am). - nursing staff to phone Emma's mother to prepare her for this. (- S. Ayrshire SW:)	
15.30	Emma returned from meeting with Mrs Byers, school guidance teacher & asked for feedback from meeting. Nursing notes for meeting were read to her. She accepted plan (as above) & when urged to go home on Sunday, answered that she would consider this.	
6/10/05 7.10pm	Feeling low today, initially spending time in bedroom. Went to school for afternoon to visit guidance teacher teacher, feels this went alright. Spent time in day meeting with Emma, discussing her feelings. Met at 9.45AM, 4.15PM and 7.40PM for 25 minutes in total.	
6-10-05 4:05pm	Emma appeared settled on onset of shift, spending time in the company of peers. Emma's mood appeared to dip at bedtime, stating that she was feeling low. Encouraged to use distraction at which stage she tidied her room and chatted with fellow peers L^{mk} and V^g. Was found to have self-harmed at approx 11.40pm. Various superficial lacerations to her left arm, using a razor blade, which was taken and disposed of. Wounds cleaned and dressings applied to deeper cuts. Nonadhesive dressing applied and bandage to secure these. Emma stated that she had racing thoughts, negative about her and was feeling helpless. Emma stated that she felt very sad and Emma managed to settle down in her bed after this, Emma fell asleep shortly thereafter and appears to have slept soundly through the night. IRI completed.	

FORMATIVE EVALUATION

PATIENTS NAME Emma Lindsay

UNIT No. T/1778682/1

DATE OF BIRTH 26.8.90

WARD/DEPARTMENT Adol. Unit.

DATE	FORMATIVE EVALUATION	SIGNATURE/DESIGNATION
7/10	8mo review - ecoton Emma feels her mood has been quite low over the past week. Has been self harming lot this at night - says this is where derogatory voices/thoughts are most bothersome and hard to deal with. Thinks the fact that her pin has been discontinued is a factor - "It made me sleepy and able to relax" Spoke about how she interprets this - does she feel we are invalidating her symptoms? Doesn't overtly feel worried about discharge, but we spoke about some of the difficulties & stresses that may arise. That She still feel Emma is much more anxious about d/ch than she is admitting to, and this may be behind recent behaviour - self harming, vomiting & restricty diet. Plan - Dr to meet with family this afternoon - OT maybe do a couple of relaxation classes with her - Needs to be encouraged to engage in dishwashing techniques	

[illegible]

FORMATIVE EVALUATION

PATIENTS NAME Emma Lindsay UNIT No. Adol Unit.
 DATE OF BIRTH 26-8-90 WARD/DEPARTMENT Adol Unit.

DATE	FORMATIVE EVALUATION	SIGNATURE/DESIGNATION
7.10.05	First contact made mid-morning but Emma requesting a change of t. model nurse, preferring a female member of staff. Lorna has "hung out" in the ward & has worried (been error NM) about peer SC's conf. hearing. She enjoyed a take-away at tea time. She appears bothered by the need to cancel planned home visit on Saturday. She declined repeatedly, final tidal model contact to renew day & nursing notes.	S/N.
8/10/05 0600	EMMA initially bright & sociable with peers on the units. Moral lowered when she went to bed. Emma was approached by myself to assess mental state. She was lying on top of bed, no eye contact & delivery low monotone voice. Emma stated she was experiencing a voice that she had never had before. The voice apparently told her to harm other people not just herself. Emma could not elaborate on this and was advised by myself to use distraction to fall asleep and discuss in the morning. Emma agreed to this. Settled to bed at 12.45am and appears to have slept overnight.	RMW
8/10/05 19.45 hrs Nursing	Emma enjoyed a long lie today. Attempted to get in touch with Emma's social worker to inform her of decision of yesterday's family meeting & the cancellation of Emma's home visit but unable to get in touch with her. Visited by Social Worker & informed her of decision. Social Worker stated she would get in touch with Emma's mother & attempt to get her onboard in Emma's care. Social Worker spent some time with Emma & informed her that supported accommodation wasn't a logical option for her due to her being under the age of sixteen. Spoke about different options that were perhaps available to Emma in the long term & about building a better relationship with Emma. Emma accepted this & agreed to see the Social Worker on the unit @ 12pm on Monday. Emma accepted this in a mature & calm manner. Went out to the cinema in the afternoon & appeared to enjoy the film. No evidence of mental distress, engendered difficulties noted.	

DATE	FORMATIVE EVALUATION	SIGNATURE/ DESIGNATION
09/10/05 Nursing 07:00	Emma bright and sociable with peers. Spent most of the evening in dining area. Settled to bed at 12:00 am, NO management problem.	RMH
9.10.05 07:05pm	Emma states that she has felt bright for most of the day however states she experienced auditory hallucinations telling her to vomit following her evening meal. Emma responded to some had purged directly after her dinner. Emma also states that she had made scratches to her arm however reluctant to reveal same. Assured with that these did not need attention. Emma appeared facially bright during interaction with staff and Emma discussed possible precipitants to this behaviour however unable to pinpoint exact precipitant. Discussion interrupted as brother visited. Emma will approach staff with concerns over symptoms later, if not managing.	
10/10/05 Nursing 08:00	Emma reported no difficulties to staff. Appeared appropriate in mood and manner and settled to sleep at 11pm. Appears to have slept overnight.	RMH
19.30hrs	Met with Emma today as her tidal nurse. Emma reported have hearing voices telling her to be sick to get rid of any food she had has eaten. Therefore was acting upon this and inducing vomiting. Also reported feeling like "shit" not going home until social work found her a placement with a foster family or home. Seemed settled in behaviour + manner. Attended scheduled groups.	
11/10/05 06.10	Emma has been settled in mood. Spent time with peers in games room. Retired to bed, however expressed difficulties sleeping. Noted to have peer peer MH laptop in her bedroom, stating she was using it for distraction as she couldn't sleep. Staff to make sure MH laptop remains with MH and is not given to Emma to borrow. Same to be discussed with Emma today. Slept from around 12pm.	RMH
11.10.05 1:05pm	TEAM MEETING - Following family meeting, Mum and partner very angry with Emma and the unit. Mum believes that staff have influenced Emma's decision not to return home. Mum	

FORMATIVE EVALUATION

UNIT No. T/1778682/1

PATIENTS NAME Emma Lindsay

DATE OF BIRTH 26-8-90 WARD/DEPARTMENT ADOL UNIT

DATE	FORMATIVE EVALUATION	SIGNATURE/DESIGNATION
	perceive that Emma has been disclosing information that is inaccurate and referred to her as being a "compulsive liar". Mum dissatisfied with Emma's diagnosis and disgruntled about lack of liaison with staff regarding Emma's care. Team concerned that mum is emotionally abusive to Emma. Social work unclear of specific package of care suitable for Emma and may look at planning and implementing a unique package focused on her current needs. Staff to continue to pursue social work progress. D. will take on this task.	
11/10/05	T/C (Social Work) summarised family meeting. Mary has arranged to meet with mum + Mary on Wednesday 12/10/05. SW meeting to pull together care plans on Thursday 13/10/05. Lynn Craig SW. → will attend to represent Ward. Meeting on Tues 18/10/05 with SW on Ward - 1pm to be invited. Secretary to cancel r/v appt tomorrow & parents. D/W Emma → has had some contact & mum says they are both "trying" with each other. Feels Mary is making it harder for her to reconcile with mum but acknowledges that Mary is supportive towards mum and has been good to her in the past.	

DATE	FORMATIVE EVALUATION	SIGNATURE/ DESIGNATION
11/10/05 19.10	Emma was in bed until the afternoon, once up she seemed bright in mood, interacting well with peers. Emma stated that she was not happy with her review being put back to a later date and thought that she would be getting discharged this week. She seemed upset about this but brightened up & attended the meeting with architects about new ward.	SLU N/A
11/10/05 05.00 am	Emma has been settled in mood. Spent time with peers in games room. Refused snack. Stated she still has difficulties managing food, and continues to vomit when managing meals. Emma wrote down some points that she felt would help her reduce - self-harm, vomiting, and to encourage her to attend school and groups. Emma feels she needs a lot of support and guidance at present particularly around her eating difficulties. Nursing staff to be aware that Emma may attempt to vomit after meals, and offer support at these times. Emma stated she was finding it difficult to sleep at bedtime. Read her book for a while then eventually fell asleep around 12pm. Slept thereafter. Earlier in the evening Emma spoke to mum and stated that mum said she wasn't looking forward to the social work meeting as she didn't like social work. However, stated that she would do it for Emma. Emma also stated that she asked mum for some money but mum refused same. Spoke about feeling as if mum was more interested in "Marty" than her, and spoke about feeling as if mum doesn't care. Re-assurance given.	EMW SLU
12/10/05 19.10	Met with Emma on a number of occasions today as per belief model. Emma appeared fairly bright attending classes and mixing with peers. On speaking with Emma re discharged her meals and she stated that she "doesn't want to eat as when she eats the voices tell me to be sick". Emma was fairly apathetic when I attempted to get her to utilize distraction to get her through meal times. Emma continued to refuse meals today. Emma also spoke about benefits. I enquired about this and an application pack for Disability Living Allowance for Children is being sent out to her.	

TEAM MEETING

KELVIN TEAM

EMMA LINDSAY

11TH OCTOBER, 2005

NURSING REPORT

Increased self-harm behaviours.

MEDICAL REPORT

Has been bullying peers. Dr [redacted] poke with her. Made is clear that she would be discharged if this recurred. At review meeting, community team representatives agreed that Emma's difficulties lie within her personality and with her home relationships.

CURRENT PSYCHOTROPIC MEDICATION AND WORKING DIAGNOSIS

PSYCHOLOGY REPORT

ould like to be involved in meeting SW Team re suitable placements.

TEAM MEETING

KELVIN TEAM

EMMA LINDSAY

11TH OCTOBER, 2005

DIETITIAN REPORT

OCCUPATIONAL THERAPY REPORT

OTHER DISCIPLINES – PHYSIO, ETC.

SCHOOL REPORT

SOCIAL WORK /FAMILY WORK REPORT

Very difficult family meeting.

GROUP WORK REPORT

RISK ASSESSMENT

DECISIONS AND PASS ARRANGEMENTS

- Liaise with Social Work – Dr [redacted] and arrange another meeting.
- Dr. [redacted] and Dr [redacted] to Mum and Mary.

GREATER GLASGOW NHS BOARD - PRIMARY CARE DIVISION

FORMATIVE EVALUATION

UNIT No. T/1775682/1

PATIENTS NAME EMMA LINDSAY

DATE OF BIRTH 26.8.90

WARD/DEPARTMENT ADU

DATE	FORMATIVE EVALUATION	SIGNATURE/DESIGNATION
cont	Emma seemed pleased with flats. At time of writing Emma is settled with peers etc. Electrician room.	
13/10/05 05:30	Emma has had a very settled night, mood and behaviour appropriate. I noticed 1 snack although noted to have stuffed her pockets with sweets from fellow peers party. Found in razor blade and a broken up night bulb, stating she didn't want to self harm. Given a lot of praise for same. Emma hid the razor blade in the bottom of her curtain. Spent time with peers, and hid in room before returning to bed. Slept from around 1am.	N/A emma
13/10/05 18:15	Emma states her day has been "alright". Staff Nurse attended Social Work meeting for Emma. At this meeting decisions were that Emma remains in hospital whilst other accommodation is being looked into. Emma has clearly stated that she does not feel ready to go home to Mum at present. Staff Nurse reminded Emma of the Unit's zero tolerance policy with regards to bullying peers. Emma was reminded at this time of a discussion with Doctor Gardiner. Emma attended all of her timetable scheduling today and was able, with support, to attend physiotherapy. Emma describes her mood as "average" today. These notes have been written with Emma and agreed with by Emma.	
14/10/05 06:30	Emma was settled in mood and behaviour, although noted to be a little grumpy at times. Spoke about speaking to her mum on the phone, and stated that mum is very angry because Emma got Social Work services involved in her care. Emma states that mum said she didn't want to know her anymore. Emma was quite angry and upset with same. Stated that mum doesn't want her returning home now, and she didn't	

DATE	FORMATIVE EVALUATION	SIGNATURE/ DESIGNATION
	want to return home. Spent time interacting with peers. Retired to bed when prompted. Continues to express difficulties getting to sleep, however slept from around 12:30pm. Nameel mine disrupted with Emma that they would start work on developing self control, and self esteem. Emma states she is eager to do same.	RMN

14/10/05. TIC to Social Services
- message left for Margory Millar /L,

NB Emma involved in bullying behaviour towards other peers on the ward
- in discussion w Dr
it ~~was seen~~ is felt that Emma's conduct is deteriorating (although her MSE is stable)
∴ social work to be asked to find accommodation for her by next week in view of this
Margory Millar telephoned back + informed of above.

SBR

14/10/05 Meeting w Emma & Dr.

Re - bullying

Says she had fallen out w Lorna McK yesterday - thought she was staring at her - calling her names in class

Denies being bullying towards other peers

Dr explained to Emma that this behaviour was unacceptable - Emma agreed.

Re weekend - wants to go out unaccompanied - Dr advised that she can have an afternoon out on pass.

Plan: Unaccompanied pass - up to 4hrs at a time over the weekend.

SBR

PATIENTS NAME EMMA LINDSAY

DATE OF BIRTH 26/8/90

WARD/DEPARTMENT MCV

DATE	FORMATIVE EVALUATION	SIGNATURE/DESIGNATION
14/10/05	Made contact 2 times with Emma today and she spoke to Carolyn Donaldson at length. When I spoke to her she said everything was fine. She spoke to Carolyn about that but her behaviour is least from her mother and this makes her sad. Mrs. she does not want to be discharged from here to a Social Services home. Emma needed limits and boundaries in her behaviour today, i.e. putting feet on furniture.	
15/10/05 06:30	Emma has been quite irritable at times throughout the evening. States she feels worried about what is going to happen to her when she gets discharged. She spoke about looking forward to living with a foster family as she feels a lot of her behaviours are learned from her mum, and that she would like to be taught "normal" behaviours, and more effective coping strategies. Commenced "self control" work set by named nurse. Emma was also prompted to complete diary work. Emma watched t.v with peers, then retired to bed.	✓
15/10/05 Nurse 19:15	Met with Emma on several occasions as her allocated nurse. Emma has been visual around the unit spending long periods of time with peers both in her room and public areas. Emma has conducted herself well today to problems, evidently still has to be prompted at meal times, but does manage. At time of writing Report Emma was settled.	RMN
16/10/05 05:00	Emma has been settled in mood most of the night; spending time with peers in the t.v room. On one occasion became a bit boisterous and threw a plastic bottle of juice at peer St. Spoken to re scene, and bottle put in the bin. At bedtime, Emma started tidying her room and at one point became very fearful and upset stating she was missing her dad. Feels that "things would be different" if he was still alive. Advised Emma to write down some of her thoughts, which she did, and handed into	

DATE	FORMATIVE EVALUATION	SIGNATURE/ DESIGNATION
	named nurse. Emma had written about the loss of her dad and how she feels guilty as she never told him she loved him before he passed away. Emma then retired to bed and eventually fell asleep. Emma has completed diary work, and done some worksheets on self esteem and self control as set by named nurse this evening.	RMN
16/10/05 morning	Had to speak with Emma today as she approached staff to let her outside for a smoke. Emma was approached by myself about her having cigarettes without eating. Emma was spoken to about this which she did take exception to and began to argue with me about how she doesn't have to eat. I can't tell her she can't smoke and she will leave if I do so. At that point I spoke to Emma in her room, I pointed out to Emma her behaviour was unacceptable and she agreed and apologised.	sign
16/10/05 morning 19.15hrs	Emma stated that she is 'off' day today but that following on her thoughts last night, her mood has improved. Met with Emma today as her named nurse & Emma's mood did appear low @ times & also refusing food at some points. During discussion with Emma she stated that her voice was telling her not to eat. Discussed challenging 1000 after feelings & looked @ 10 a day (eating). Discussed Emma's relationship with her mum. & Emma stated she is no longer bitter that she doesn't have a relationship with her & it is her loss. Spoke about not using her unaccompanied passes @ the weekend. Encourage Emma to use these passes to build up confidence out of the unit as the long term plan is for Emma to remain here. Emma accepted this & agreed to try & use passes tomorrow.	Scal
17/10/05 0600	Emma was settled in mood and behaviour. Spent most of the evening watching T.V with peers. Spent time reading, and filled in diary work before retiring to bed. Slept overnight.	RMN
18.15hrs.	Met with Emma carson as her TIA Nurse today. APPEARED SETTLED THROUGHOUT THE DAY. MOOD APPROPRIATE. ENJOYED GROUP DURING. NO SIGNS OF Nausea AFTER MEALS. INTERACTING WITH PEERS	

GREATER GLASGOW NHS BOARD - PRIMARY CARE DIVISION

FORMATIVE EVALUATION

UNIT No. 1/1778682/1

PATIENTS NAME Emma LINDSEY

DATE OF BIRTH 26/08/90

WARD/DEPARTMENT A.D.U.

DATE	FORMATIVE EVALUATION	SIGNATURE/DESIGNATION
18/09/05 05:30	Emma appeared bright and pleasant in her interactions last night. She retired to bed at 23:00hrs and appears to have slept well from 00:15hrs. requested and received P.R.N. Paracetamol for headache at 00:05hrs	
18/10/05 15:00.	Team Meeting: ongoing planning with S.W. continues for discharge - this may be into a specialized foster placement. Limits need to be set on anti-social behaviour - bullying etc. Self-esteem and impulse control work to continue. Dr Gardiner suggests a visit to her brother may be beneficial. Also that Emma may be at risk of substance misuse.	S/N
18/10/05 19:30 Nursing	Met with Emma on several occasions today as her allocated nurse. Emma has been active around the unit today, and mixed well both with peers and staff. Emma met with nurse today, who was quite fearful for Emma. Emma's mum only stayed for 10 minutes, after which staff spoke to Emma giving her supper which Emma was happy to receive. Emma again had poor dietary intake and Emma was challenged about this at the time. Emma did take this on board and managed to eat her meal. At time of writing report Emma was settled.	S/N
19/10/05 Nursing 08:00hrs	Emma remained settled this evening, socialising well and appropriately with peers. Good humoured, and good company throughout the evening, no concerns of note. Appears to have resolved earlier conflict with fellow peer C.M.P. Late to settle but agreed she had had a really fun evening and was looking forward to a night ahead tomorrow. Emma's mood and behaviour remained appropriate and she appears to have fallen to sleep at around 01:00hrs	
19/10/05	Attended outing. Appeared bright, cheerful, sociable. She does however test boundaries with staff. Emma also appeared in training of other young people which seems quite appropriate. Laughing with other about particular young people. Therefore will discuss this with Emma tomorrow.	
19/10/05	Met with Emma, on several occasions today as her named nurse. Emma has had a fairly structured day, mixed well with staff and peers. Emma thus tackled her dietary needs and managed well with prompting. Emma enjoyed the outing and was in an agreeable mood. Evident and overall had a good day.	S/N

DATE	FORMATIVE EVALUATION	SIGNATURE/ DESIGNATION
20/10/05	Emma spent the majority of the evening in company of peer S.C. in games room, playing computer and appeared bright + settled, Appropriate in mood and in behaviour. Had a disagreement with peer L.MCK after supper and became very loud and resentful about this, stating that she felt very angry and was finding it very hard to control this anger. Kicked pillows in her room however then chose to go and sit in the school area to "calm a bit". Managed this and also spent time with staff in order to de-escalate. Appeared upset and disappointed re comments made in passing by peer L.MCK after Emma had told staff about another young person smuggling. Emma had been called a "grass" and appeared genuinely upset about this. Staff reassured Emma that she had been correct to inform staff. Emma was slow to settle, in and out of her room however not disruptive and remained calm and settled in mood. Eventually Emma settled and slept at around 0200hrs. Emma was noted to have done some diary homework set by key worker before going to sleep.	
20.10.05	Accompanied to play pool. Emma seemed a little flat in mood initially. She reported feeling annoyed with peer (L.MCK) as both were not getting on. Therefore informed Emma that playing staff pool to meet with both groups to establish a some common ground for the next help resolved situation & make life easier for both parties. Following this conversation Emma enjoyed playing pool with staff.	KAW
10/05 17.05hrs	Spent time with Emma today as per tidal model Emma noticeably annoyed with peer L.MCK, as noted above. Emma spent time out this afternoon and enjoyed this. On return L.MCK approached Emma to discuss events and issues between them. Emma remains angry about their relationship and said she "would only give L.MCK another chance". Emma appears content at present and is opening time in the dining area at time of writing.	N/A
20/10/05 04:30	Emma appeared bright and pleasant last night interacting well with peers, refused to bed at 20:00hrs, appears to have slept well.	/ /
21/10/05 13:30hrs Nursing	Spoke with Emma today as Tidal nurse Emma stated that she was feeling very positive about her self today as she has been in contact with her Mum Gran and brother, and that she also had a chat with fellow peer C.S. about the future and about what she wanted to do with her life. Emma also stated that she would like some time out with her mum for a short period if that would be possible. Staff told Emma that they they would find out if it	

TEAM MEETING
KELVIN TEAM

EMMA LINDSAY
18TH OCTOBER, 2005

DIETITIAN REPORT

OCCUPATIONAL THERAPY REPORT

Didn't attend supper group.

OTHER DISCIPLINES – PHYSIO, ETC.

SCHOOL REPORT

SOCIAL WORK / FAMILY WORK REPORT

GROUP WORK REPORT

RISK ASSESSMENT

DECISIONS AND PASS ARRANGEMENTS

- Dr meet SW today – plan discharge.
- Continue self-esteem and impulse control work.
- Limits on anti-social behaviour.
- Keep timetable structured.

NURSING REPORT

Objectively bright and interactive.
Subjectively reports mood fluctuations – related to uncertainty re discharge.
Still complains of command auditory hallucinations telling her to vomit after meals – staff trying to extinguish.
Exploring loss of Dad with staff.
Ongoing work re self-esteem.

MEDICAL REPORT

Discharge asap. Dr [redacted] meeting SW today.
Will be received into care – specialised foster care.
Can distract herself when distressed.
Dr [redacted] and Dr [redacted] met with Emma last week to look at anti-social behaviour.

CURRENT PSYCHOTROPIC MEDICATION AND WORKING DIAGNOSIS

Evolving borderline difficulties.
No medication.

PSYCHOLOGY REPORT

WARD ROUND

KEY POINTS AND ISSUES:

- Continues to have difficulty complying with care plans & school.
- Objectively Emma is settled in mood, although Emma states her mood continues to fluctuate.
- Continues to be quite bawdy at times requiring limit setting.
- Spoken to by Dr Hardman re bullying.
- No evidence of Emma responding to any voices, although Emma continues to report that her voices are telling her to vomit after meals.
- No self-harm risk were - Emma handled in sharps - (blade + glass) to prevent her from doing same.
- Worried about the possibility of discharge & what will happen to her.
- States mum doesn't want to know her anymore due to her involving SW + not wanting to go home.
- Tearful on Sat night - stating she missed her dad, + spoke about feeling guilty for not telling him.

RECOMMENDATIONS:

- She loved him before he died.
- Warned that same may happen with mum, whereby mum will think she hates her.
- Commenced work on self esteem / self control.
- Emma managing to complete diary work.

Recommendations

- Continue to liaise with SW re accommodation.
- monitor mood + behaviour
- observe for any bullying / unacceptable conduct
- continue work on self esteem / self control.

FORMATIVE EVALUATION

UNIT No.

PATIENTS NAME

DATE OF BIRTH

WARD/DEPARTMENT

SIGNATURE/
DESIGNATION

DATE	FORMATIVE EVALUATION	SIGNATURE/ DESIGNATION
21/10/05 13:30 Nursing	would be possible for her to go Staff also gave Emma praise for all the hard work that she was doing regarding contacting her mum. Emma also stated that she was still having difficulty eating Staff informed Emma that they would encourage a healthy eating plan and would work with her regarding same Emma's mood appears bright at time of writing	
21/10/05 MEDICAL	SPR Review Feeling OK mood good - feels better now has met c sw etc. Spoke c Mum + gran + Mary on telephone last night managed not to get into a confrontation - felt very pleased with herself Asking to go home to visit mum tomorrow - just for a short time Discussed how this might be difficult as has not been home for sometime + has only just re-established contact. Suggested mum might want to visit her on the ward + possibly take her out for 1 hr - Emma agreed to this + stated she would contact her mum. Self harm - nil recently continues to vomit intermittently after meals Mood - generally bright interacting well c peers talking about future plans → wants to be a hairdresser. MSE: Smartly dressed Short sleeves - old self harm cuts on arms - nil recent good ec + Rppot pleasant + coop No signs of agitation / distress speech N rate + vol	

DATE	FORMATIVE EVALUATION	SIGNATURE/ DESIGNATION
21/10/05	mood - euthymic & reactive affect Nil suicidal Nil psychotic Comp ✓ Insight - Agreeable to Rx plan <u>Plan</u> • Emma to phone me to ask about visit at weekend (with 1-2 hrs out in Kale with mum if desired) • Messages left with Marjorie Millar re possible placement - Marjorie unavailable at present • NIM call back later - Dr / Dr ... to discuss & her. VSPK	
22/10/05	settled evening, discussing discharge next week 4-30am with both night staff and peers. Appears positive about placement and leaving the unit although stated she will "miss everyone". Spoke with mum and has made arrangements to go out with mum on Sunday afternoon. Settled and slept from 1am.	S/N

GREATER GLASGOW NHS BOARD - PRIMARY CARE DIVISION

FORMATIVE EVALUATION

PATIENTS NAME EMMA LINDSAY

UNIT No. T/1778682/1

DATE OF BIRTH 26/8/90

WARD/DEPARTMENT ADOLESCENT

DATE	FORMATIVE EVALUATION	SIGNATURE/DESIGNATION
22/10/05	SPENT DAY SOCIALISING WITH STAFF/PEERS.	
1925hrs	HAS EXPRESSED POSITIVE FEELINGS ABOUT LEAVING THE WARD AND SOME NATURAL ANXIETY'S ABOUT DISCHARGE TO, WENT ON CINEMA OUTING AND ENJOYED THIS IN TUTOROOM WITH STAFF/PEERS AT TIME OF WRITING.	1/1 S/A
23/10/05	Settled evening, spent with staff and peers.	
04 ⁰⁵ hrs	Appeared in good spirits, late to settle, having to be prompted by staff several times to put lights out and go to sleep. Appears to have slept from 02 ⁰⁰ hrs onwards	S/W
23/10/05	met with Emma on several occasions as nursing her Tidal model nurse. Emma acknowledged that she was apprehensive regarding discharge next week. Appeared to be managing anxiety well and has been interacting with both peers and staff appropriately. Emma was due to be visited by her mum today. This was cancelled due to her mum being unwell. Emma appeared accepting of this, declined the opportunity to write notes collaboratively with writer.	
24/10/05	settled in early part of evening. 10 minutes before lights out found practically clearing bedroom very fearful stating she is going to contact her S/W and ask to leave with later today. Feels uneasy about placement and how she will like it, just wants leaving the unit to be over and done with. Responded well to reassurance that her fears were understandable. Slept from midnight.	S/W
24/10	D/W Emma Anxious about all the uncertainties of her placement. lots of questions about what it will be like, the rules, the school etc Also very apprehensive about saying "goodbye" to staff/patients. Just wants to "leave now" Will phone allow some of Emma's questions to be answered. Told her it is unlikely she will be able to leave today, but reserved	

DATE	FORMATIVE EVALUATION	SIGNATURE/ DESIGNATION
	her all the worries are entirely appropriate.	
	- while on another call phone back.	
19 ⁰⁰	Emma has appeared bright after a long morning in bed. Playful with peers and staff, Emma appears to have mirrored her mood. She has been wondering where she will be going to and she states she can't wait to go. Her preparations including ordering her clothes onto next stages. Generally settled in the unit.	
25/10/05 06.15	Emma has been very settled in mood throughout the morning, spending time with peers. Complained of "pins and needles" in her hands; and found it difficult to settle to sleep. Stated that she was excited about her discharge. Retired to bed around 1am.	RMM
25.10.05 12:45pm	TEAM MEETING - Plan for discharge to care division ⁱⁿ residential home tomorrow.	
25.10.05 2000hrs Nursing	Emma appeared to have a settled day today. Had a leaving party & appeared to enjoy the same. Spent time with peers & staff, interacting well with both, no problems noted.	
26/10/05 0800 Nursing	Emma has been very settled in mood and behaviour. Became a little tearful when saying goodbye to Dr Gaston, and feeling a little overwhelmed with the idea of being discharged, and not seeing staff and peers again. Spent time speaking with named nurse, and spoke about anxieties and fears re coping on her own. Re-assurance given which Emma accepted. Spent time interacting with peers and organising her belongings for discharge. Slept well overnight.	RMM

TEAM MEETING

EMMA LINDSAY

KELVIN TEAM

25TH OCTOBER, 2005

NURSING REPORT

Doing well.

Has a supported accommodation placement to begin tomorrow in Thornhill with Care Visions.

Dis-engaging from the Unit in readiness to leave. Re-engaging a little with mum.

Unit in Thornhill will organise a home-based tuition package initially and work towards school attendance.

MEDICAL REPORT

CURRENT PSYCHOTROPIC MEDICATION AND WORKING DIAGNOSIS

PSYCHOLOGY REPORT

TEAM MEETING

EMMA LINDSAY

KELVIN TEAM

25TH OCTOBER, 2005

DIETITIAN REPORT

OCCUPATIONAL THERAPY REPORT

OTHER DISCIPLINES – PHYSIO, ETC.

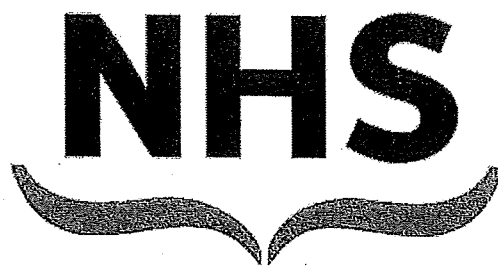
SCHOOL REPORT

SOCIAL WORK /FAMILY WORK REPORT

GROUP WORK REPORT

RISK ASSESSMENT

DECISIONS AND PASS ARRANGEMENTS



**Greater
Glasgow**

PROGRESS REPORT
DATE: 7TH SEPTEMBER, 2005

EMMA LINDSAY

**ADOLESCENT UNIT,
GARTNAVEL ROYAL HOSPITAL,
1055 GT. WESTERN ROAD,
GLASGOW G12 0XH.
Tel:**

Present: Dr [redacted] (Chair); Dr [redacted]; Dr [redacted]
Staff Nurse [redacted]

Apologies: Linda Brown (Head Teacher); Mrs Byers (Guidance Teacher);
[redacted] Nurse Therapist; [redacted] Locum Consultant Adolescent Psychiatrist

In
attendance: [redacted] (Minutes)

Dr [redacted] opened the meeting with a brief outline of the proceedings and gave an introduction of Emma's history prior to being admitted to the Adolescent Unit on 19 July 2005 for a period of assessment.

Emma was referred from Ayrshire, where she had spent up to 10 weeks in hospital due to concerns that she may have serious psychiatric problems.

NURSING REPORT

Since admission Emma has settled into the ward, showing very good insight into her difficulties. Initially Emma stated that she had three main issues that she wanted to work on, including managing her auditory hallucinations, coping skills for self-harm and binge eating, which have all been addressed through nursing care plans. Emma has responded well to these nursing interventions, although at times requiring a lot of firm limit setting.

Initially Emma reported that her mood was mostly low, and voices were loud, particularly at night, resulting in some incidents of self-harm. However over the past six weeks, Emma's mood has become more settled with very few periods of low mood and a decrease in self-harming behaviour noted. Emma has been able to approach staff when experiencing difficulties and has responded well to support and reassurance. Emma has been monitoring her mood and the intensity of the voices through the use of diary work, however, she continuously needs prompting to complete same. There doesn't appear to be any clear pattern or relationship with Emma's mood and her voices, and objectively there has been no evidence of pre-occupation with unseen stimuli.

Emma reports that a female voice in her head tells her to vomit, which she has acted on over the past month. Emma states she feels lonely and angry before binge eating and just prior to self-induced vomiting, and describes a release from emotions and thoughts. Nevertheless, there has been a decrease in this behaviour recently, whereby Emma states that she feels able to distract herself, and challenge the negative thoughts most of the time. Emma has been commenced on a healthy eating plan, which she has found very difficult to comply with, requiring staff guidance and encouragement.

Overall, Emma's behaviour has become more settled around the ward since admission. Initially Emma became easily irritable and argumentative with both staff and peers, resulting in various incidents of verbal aggression and destroying property, thus requiring a lot of limit setting. Emma admits to finding this very difficult, but very helpful too. Emma has recently been very pleasant, interacting well with peers and staff most of the time, although noted to be quite over-familiar with male patients, requiring reinforcement of boundary issues. Attending to school timetable, groups/outings and unaccompanied walks with no problems.

However, struggling to manage home passes. Emma was to have two overnight passes last weekend and was unable to manage same, stating that she felt it was 'too much'. Mum's partner phoned the unit and stated that the pass wasn't convenient for them either and wanted to change it the next week, resulting in Emma going out on a day pass only. Objectively Emma is very settled in the ward, and has stated to staff that she doesn't want discharged.

MEDICAL REPORT

Report by Dr [redacted]

Emma was admitted to Adolescent Unit for a full assessment of her Mental State for clarification of her diagnosis. She was transferred from Crosshouse Hospital where she had been an in-patient since April/May 2005. She was admitted there following repeated attempts to self-harm and escalating behavioural difficulties at home. She had been told that she had Bipolar Affective Disorder/Borderline Personality Disorder/ADHD. She was being treated with risperidone, carbamazepine and zopiclone.

At the time of admission Emma was complaining of voices inside her head that told her she was worthless, fat and ugly. These voices were female and spoke directly to her. They were worse at nighttimes and

sometimes prevented her from sleeping. She was also complaining of some visual hallucinations. She described her mood as being low all of the time (2/10) however when asked in more detail she was able to describe times when her mood was much better than this. She said her concentration was poor, however her energy levels were ok. She had a good appetite and did not complain of a loss of interest or pleasure in activities. She described initial insomnia – she did not sleep until 4am, but there was no early morning wakening. She did not have any wish to die and on the occasions when she had taken overdoses in the past she had sought help immediately. She stated that the self-harming behaviour was often in response to feeling low or upset about something and that she felt the voices told her to do this. She would scratch her legs/arms with her nails and this gave a temporary relief to her anxiety. At the time of admission she was harming herself infrequently (twice in a fortnight).

Progress on the Ward:

Emma settled quickly into the routine of the ward. Her zopiclone was discontinued and with the establishment of a bedtime routine and good sleep hygiene her sleep pattern returned to normal. She was asked to keep a diary of her mood and of when she was troubled by voices. Unfortunately she only felt able to do this for a short time. However it was noted that she was bright in mood on the ward, participating in ward activities and interacting well with peers.

She self-harmed on a few occasions. These incidents were usually precipitated by a disagreement with another peer on the ward. Emma would describe the voices telling her she was worthless and feeling the only way to relieve this would be to harm herself. On further questioning Emma would describe feeling low in mood. She was encouraged to try to describe her feelings at these times in terms of thoughts rather than the voices.

Emma's medication has been gradually reduced and she is now on no psychotropic medication at all. There has been no deterioration in her mental state. In fact her mood continues to be bright and she has not self-harmed for some time now. She began to vomit after meals for a short time, stating that the voices told her she was fat and ugly. This behaviour settled quickly with dietary advice from nursing staff and a behavioural chart.

When asked directly she continues to complain of voices at night, however she has not been observed to be distressed at these times and her sleep pattern has remained normal. Emma says she is able to distract herself and therefore does not inform staff when the voices occur.

Emma has had passes to home. These have been difficult at times with Emma becoming anxious and hearing voices. She has had to return to the unit early as a result. Emma says she feels under pressure to be well at home and becomes agitated when her mum or Mary asks her to do things.

Medical Update Report by Dr

Emma has now medication free for a week or so, with the small residual dose of Carbamazepine being discontinued on 30/08/05.

Subjectively, she continues to report her mood fluctuating regularly, but objectively staff have noted Emma to be cheerful around the ward, and interacting appropriately and well with other patients and staff. At times of stress, she reports derogatory voices telling her "You're fat / ugly / worthless", these voices are worse at night-time and when she is at home. They don't really seem to have the quality of true hallucinations. Staff have asked Emma to inform them when she is experiencing these voices.

There has been no clear psychiatric pathology with Emma, but she is having some difficulty accepting the idea that she does not suffer from a mental illness. She is very settled and happy with the company and support of the ward environment, and it is proving tricky to get her thinking about discharge. She has been very reluctant to try passes home overnight, and ambivalent feelings about having Emma home seemed to be shared by mum, who seems ready to put up barriers to passes. Emma finds it difficult to confide in mum, because she feels her mother has so many things to deal with of her own. Also, mother seems to have difficulty setting boundaries for Emma and tends to deal with Emma's outbursts and behaviour by giving in to what she is asking for.

Emma had a short period of self induced vomiting in the middle of August, which she reported to staff and seems to have been short-lived. She reports similar behaviour happening two years ago for roughly six months when she was trying to lose weight. Her behaviour at the time might have been related to the emotional upset of her mum being on holiday without her for the first time.

She has been seen by a ward dietician regarding a desire to lose weight. She has been given an eating plan, but she has been struggling with this at times.

CURRENT MEDICATION

None.

FAMILY WORK REPORT

Report by Dr

There have been two meetings with

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UNIT SCHOOL REPORT

Update:

Emma is working with us on 5 Standard Grades although she is constantly renegotiating classes and levels. She has difficulties being consistent.

Mainstream School Report:

Emma moved to Ayr Academy from Prestwick Academy where she had been suspended for behaviour issues. She has settled in Ayr and made an effort to integrate. She has several difficulties:

- she has a slight Dyslexia / learning difficulty which has not been assessed as requiring extra support in class.
- she has problems socialising, though keen to make friends she cannot find the correct way to do this and falls out with the group.
- she is self-conscious about her looks.
- with teaching staff she can be a bit "stroppy" if she does not get her own way.
- she does not like to do written work in class and prefers aural work.

Unit School Report:

Emma is working at Foundation / General level. She lacks confidence and tends to deal with this by getting oppositional or asking to leave class. We have built in short breaks and early leaving from classroom to support maintaining school.

She does a lot of negotiating to change curricular content and subjects, or as a last resort, just refuses to attend.

She is managing most subjects she is in but very distractable in class and prefers to engage with peers. She has not attended Mathematics for two weeks.

Conclusion:

Emma has worked hard at settling into her new mainstream school but is now saying that she cannot manage to return there.

She needs a period of settled schooling to gain some self-confidence and consistent school attendance.

COMMENTS:

Dr commented that Emma may respond better to a smaller school environment and that although she is doing well in the unit school that mainstream school maybe too much. Recommends requesting

psychometric testing for Emma. Dr continued that Emma is not good socially, she gets the messages wrong, she is not empathic. She can try too hard to make friends which can result in the opposite effect. The suggestion of respite care was made. Dr suggested that Emma may have a Borderline Personality Disorder. It was intimated that Emma's home life maybe more inconsistent than being depicted to which Dr revealed that the family had moved house at least 4 to 5 times in a short period of time, which would support this comment.

CAMHS REPORT

Not submitted.

CAMHS SOCIAL WORK

Not submitted.

PLAN

- Request psychometric testing for Emma – discuss with psychology.
- Respite care – need to establish whether Social Work are involved and what services they could offer.
- Discharge Date set for Friday 14 October 2005 – in five weeks.
- Contact CAMHS to feedback and arrange an appointment prior to discharge date.
- Increasing periods of pass home prior to discharge.

DATE OF NEXT REVIEW

TBA

Contacts List

Name	Designation	Address	Contact Number
Dr	Consultant Adolescent Psychiatrist	Modular Building Gartnaval Royal Hospital 1055 Great Western Road Glasgow G12 0XH	
Dr	Senior House Officer	Modular Building Gartnaval Royal Hospital 1055 Great Western Road Glasgow G12 0XH	
Dr	Specialist Registrar	Modular Building Gartnaval Royal Hospital 1055 Great Western Road Glasgow G12 0XH	
	Staff Nurse	Modular Building Gartnaval Royal Hospital 1055 Great Western Road Glasgow G12 0XH	
Linda Brown	Head Teacher	Modular Building Gartnaval Royal Hospital 1055 Great Western Road Glasgow G12 0XH	0141 211 3552
Mrs Byers	Guidance Teacher	Ayr Academy 7 Fort Street Ayr KA7 1HX	
I	Nurse Therapist	Adolescent Team Room 1545 Training Centre Building Ayrshire Central Hospital Irvine KA12 8SS	
	Locum Consultant Adolescent Psychiatrist	Adolescent Team Room 1545 Training Centre Building Ayrshire Central Hospital Irvine KA12 8SS	

TEAM MEETING
KELVIN TEAM

(NAME) Emma Lindsay
(DATE) 30.08.05

Nursing Report

Mood settled this week.
Spells of being disgruntled.
Can be very loud. Spending time with peer SC – staff are monitoring this contact.
Binge eating reduced.
States she is bored often.
Came back early from pass saying she was edgy and scared.
Says she hears voices at home and on the unit. No evidence of this noted.
Commenced on nicotine patches but still smoking.

Medical Report

No evidence of psychotic phenomena.
No evidence of depression.
Family reluctant to have Emma on overnight pass this week because the family are moving. They feel she wanted to come back to the ward rather than do packing.
Improvement in mental state noted with reduction in medication.

Current Psychotropic Medication and Working Diagnosis

Psychology Report

has met with Emma.

PATIENT NAME:

Emma Lindsay

DATE:

23rd August 2005

TEAM MEETING

NURSING REPORT

Mostly bright and relaxed around unit.

- One incident where she swallowed tissues as form of self-harm.
- Very boisterous at times, requiring firm limit setting.
- Struggling with healthy eating regime. Vomiting and self-harming behaviours have both reduced.

MEDICAL REPORT

Not displaying psychotic features.

No deterioration in mental state since coming off medication.

Blames self-harming in voices, but it can be reflected at her it is how she is feeling.

SCHOOL REPORT

Going well, initially then became oppositional/rude.

OT REPORT

SOCIAL WORK REPORT

FAMILY WORK REPORT

PSYCHOLOGY REPORT

Not really fully engaged.

Not sure if any work needs to be done.

PATIENT NAME:

Emma Lindsay

DATE:

16th August 2005

TEAM MEETING

NURSING REPORT

Mood seems to fluctuate. Has been vomiting after meals for 2 weeks. Attributes this to a voice in her head which appears when she feels lonely or upset. Binges prior to vomiting. Complying with cigarette chart. Telephones mum regularly. Had day pass with brother.

Binging and vomiting seems to have replaced self harm behaviours.

MEDICAL REPORT

Flat at end of last week. Brighter yesterday. Spoke about being pleased she's managed to disclose her binging and vomiting behaviours.

Bright and motivated no evidence of auditory hallucinations. Able to be reflective.

SCHOOL REPORT

OT REPORT

Attending walking and sports group.

SOCIAL WORK REPORT FAMILY WORK

Dr ; begun family work. Mum has a history of schizophrenia. She has described an abusive childhood family history is very complicated.

FAMILY WORK REPORT

WARD ROUND 3018105
EMMA LINDSAY

KEY POINTS AND ISSUES:

- Emma's mood has been predominantly settled throughout the week. Episodes of low / disgruntled mood however these have been related to specific incidents, not long lasting.
- Otherwise, relaxed in manner, appropriate in interactions with staff, loud at times. Spends a lot of time in company of fellow in-patient S.C. Staff monitoring this! Found chatting in school end in the dark and advised to switch lights on.
- Diet has been finickish
 - Managing some healthy options. Binge eating & however continues to eat chocolate and meals with chips / non-healthy options stating there is nothing else.
 - Stated that she has self induce vomited once
- Generally manages to keep herself occupied however states that she gets bored.
- Ambiguous re. Passes. Overnight Pass did not go ahead, - stated she does not feel ready. Sunday 28/8 - Back early from Pass, stating she felt "edgy and scared" quick to settle however.
- 'Voices' - subjectively stating she hears these predominantly @ home but also in unit. Able to distract herself and therefore does not approach staff.

RECOMMENDATIONS:

- To continue to discuss Passes with Emma and to encourage these?
- Emma commenced Nicorette Patches today (Mon 29th) however continues to smoke. Advise re. risks of combining?
- Continue to monitor Emma's mood + behaviour for signs of auditory hallucinations
- Encourage to use mood diary. States that she does try to use this and finds helpful when she does.

WARD ROUND

KEY POINTS AND ISSUES:

- Mood has been mostly bright ~~& behaviour~~ ^{stating she feels} appropriate & relaxed in the unit.
- Spells of low mood - whereby ~~the~~ incident when she tried to swallow ~~himself~~ in an attempt choke/suffocate self.
- Emma is unable to verbalize reasons for feeling low.
- Bolivious at times with fellow peers around the unit requiring limit setting.
- Spoken to re inappropriate conduct, whereby Emma was verbally abusive towards peer Lin, and threatening in manner.
- Continues to try and comply with healthy food regime, although at times finds this very difficult.
- Binge eating & vomiting has reduced.
- Self-harming behaviour ~~↓~~
- Emma feels a bit anxious & meds being reduced.
- Managed time out with mum - states it went very well.

RECOMMENDATIONS:

- Started diary again - to monitor mood/voices/self-harm
- Encourage healthy eating
- Firm boundary setting by staff
- Diary work.

Emma Lindsay.

KEY POINTS AND ISSUES:

- Admitted to staff that she has been vomiting after meals for past 2 weeks.
- States she has a female voice in her head telling her to vomit.
- States she feels lonely and angry ^{before a} ~~during~~ binge and just prior to self-induced vomiting.
- Gets a release from emotions / thoughts after vomiting.
- Can relate variations in mood to binge / vomit cycle.
- complying with cigarette chart
- Has been phoning her Mother in Spain. Her Mother states she will contact Emma each night.
- managing to comply with healthy eating regime, although refused breakfast in AM, skipping the midday meal.

DSM - (Anorexia) - reduced,

RECOMMENDATIONS:

- Promote healthy eating skills
- offer distraction when Emma has impulses to binge / vomit.
- Encourage her to identify thoughts / feelings surrounding food.

KEY POINTS AND ISSUES:

Emma appears to have settled relatively well onto the ward mixing well with staff and peers, although has required boundary setting on various issues such as bedtime and appropriate interactions with peers.

Continues to complain of regular episodes of derogatory auditory hallucinations and has required PRN medication on a couple of occasions, but usually settles after reassurances from staff. Voicing a positive response to admission to hospital and appears to have some insight into issues regarding her mental health. Identifying 3 main issues she seeks assistance on such as managing her auditory hallucinations, coping skills for self harm and binge eating, All of which have been addressed via nursing care plans.

One episode of self harm documented since admission on 24/7 resulting in superficial cuts to arm. Symptoms appear to intensify prior to bedtime.

RECOMMENDATIONS:

Encourage group work

Firm boundary setting maintained by all staff

Encourage ventilation of feelings with staff in appropriate manner

Decisions

Respiradone decreased

Zopiclone to be discontinued.

Continue with assessment period

**PRIMARY CARE DIVISION
MENTAL HEALTH SERVICES**

PERSONAL DATA SHEET (PLEASE PRINT)

G

PATIENTS NAME	DATE OF BIRTH	HOSPITAL/WARD	UNI
Emma Lindsay	28/8/90	Adolescent	T/1775

CONTACT DETAILS			
ADDRESS:	Stonington Farm TUNNOCK PARK FARM, FALGAS KAG BSA		
TELEPHONE:	01292 561033	MOBILE:	0774971586

PERSONAL DETAILS			
NATIONALITY:	BRITISH	RELIGION:	Catholic
PREFERRED NAME:	EMMA	MAIDEN NAME:	
SINGLE, MARRIED, SEPARATED, DIVORCED, WIDOWED:			Single
OCCUPATION:	Student	NATIONAL INSURANCE No.	

PHYSICAL DESCRIPTION			
HEIGHT:	ft ins.	WEIGHT:	96 kg 200 lb
COMPLEXION:		BUILD:	
EYE COLOUR:	Brown	HAIR COLOUR/STYLE:	Brown /
DENTURES:	NO	SPECTACLES/CONTACTS:	NO
DISTINGUISHING FEATURES: [TATTOOS, SCARS, BIRTHMARKS, PIERCINGS, ETC.] Please describe and give location		Ears pierced	

ADMISSION DETAILS			
DATE OF ADMISSION:	19/1/05	TIME ADMITTED:	15:00
ADMITTED FROM:	Derbyshire Central Hosp.	ACCOMPANIED BY:	Mum + Mum
HOSPITAL CONSULTANT:		SHO/REGISTRAR:	
NAMED NURSE:		ASSOCIATE NURSES [Including night staff]	

PHYSICAL DETAILS ON ADMISSION			
BLOOD PRESSURE:		PULSE:	bpm
ROUTINE URINE SPECIMEN		TEMP:	
ADDITIONAL INFORMATION: E.g. Allergies		BODY MASS INDEX	

LEGAL STATUS ON ADMISSION:	Informal
OBSERVATION STATUS ON ADMISSION:	General observations
TIME-OUT STATUS ON ADMISSION:	None at present

SIGNATURE OF ADMITTING NURSE:	
DESIGNATION:	Staff Nurse
DATE:	19/1

Item	IRREGULAR DISCHARGE					
	[discharged against medical advice] <i>Staff have professional responsibility to encourage the individual to remain in hospital until they can either be better prepared to return to community and, or, appropriate aftercare arrangements can be made in the community.</i>			MET(M) UNMET (U) INAPPR. (I)	DATE /TIME	INIT.
7.1	Nurse in charge informs RMO/duty doctor of patient's intention to discharge themselves					
7.2	Where patient is known to a Community Mental Health Team, the nurse in charge makes request for the patient to be seen					
Patient details given to:	Name	Designation	Resource Centre			
7.3	Where patient lives outside of Glasgow, the nurse in charge makes a request for the patient to be seen by known psychiatric services or by General Practitioner.					
Patient details given to:	Name	Designation	Location			
7.4	Nurse in charge makes referral for patient in need of follow-up who has previously had no contact with CMHT					
Patient details given to:	Name	Designation	Location			
7.5	Patient informed of follow-up arrangement					
Details of follow-up arrangements						
7.6	Relatives informed of Discharge. If directed otherwise by patient, please make note in variance recording sheet					
Name of Relative informed:						
7.7	Social Work Department Informed of Discharge					
Name of Social Worker informed:						
7.8	Discharge Medication supplied to patient. IF APPLICABLE					
7.9	GP Informed of Discharge					
Name of General Practitioner:						
7.10	District Nurse informed if appropriate					
Name of District Nurse/Health Visitor:						
7.11	Advise patient if depot to be administered.					
Date depot injection next due	/	/	Location [resource centre, home, clinic etc.]			
7.12	Valuables returned: Check if any monies etc, in cash office and inform patient of arrangements for uplift.					

- ❖ Any additional discharge follow up arrangements explained to patient; detail any additional information (Leaflets etc.) within Variance Recording form.
- ❖ The responsibility of the Nurse In Charge is to ensure that the above procedures are clearly documented, with every contact being named, timed and dated.
- ❖ In the event of the patient being discharged through unacceptable behaviour, the above steps should still be followed. However, it is necessary to discuss and highlight these facts with the other care providers and ensure any alerts are communicated effectively.

Name:

EMMA LINDSAY

Assessing Nurse:

Date/Time

of Assessment: 24.7.05 13.30hrs

Others present:

Admission Summary

Informal admission to Adolescent Unit.
Transferred from crosshouse hospital
following an overdose.

Primary Nurse:

Signature:

Emma Lindsay

Date:

24/7/05

1. Complete assessment as soon as possible after admission to the service.

2. Explain the purpose of the assessment.

3. Encourage the person's active participation.

4. Record person's name and assessing nurse.

3. Record the assessment date and time

4. Record names of others present at assessment - e.g. advocate, carer, student.

5. Record brief summary of circumstances of the person's admission.

6. Inform person of name of the primary nurse and record name.

How this began:

'Didn't begin I've always had it'
"I was depressed, my mum said to the Doctor
and the Doctor got me admitted (crosshouse)"

How this affected me:

, I was quite scared and stuff.

How I felt in the beginning:

Wary, didn't trust people (crosshouse)
All the time I was there.

How things have changed over time:

Having more freedom and being able
to express myself.

I was on constant obs in crosshouse and
had to stay in my room all the time.

The effect on my relationships:

There's not somebody asking 'are you ok?'
every 2 minutes. If I need help I come
and get it.

Relationships with other young people are
fine.

closer to mum because we miss
each.

**Open-general
question: "what
has brought
you here (or)
what do you
need to talk
about?"**

**1. Problem
origins: ...so,
when did you
first no-
tice... (or) be-
come aware of
that?**

**2. Past problem
function: ...and
how did that af-
fect you at
first?**

**3. Past emo-
tions: ...and
how did you
feel about that,
at that time?**

**4. Develop-
mental history:
...and in what
way has that
changed over
time?**

**5. Relationships
...and how has
that affected
your relation-
ships with oth-
ers?**

Signature:

How do I feel now?:

I feel very sad and
lonely missing my
parents and friends

What do I think this means?:

I think that this mean
I am not very well and
may have a mental illness

What does all this say about me, as a person?:

this says that I need
help to be able to cope
and manage my illness.
as I can not live my life
this way

What needs to happen now/ what do I want or
wish would happen: I would like

to be able to manage my
illness and be able to
do my school work

What do I expect the nurse to do for me?:

I expect the nurse to help
me through my bad times
and keep my mind off things
I ~~also~~ also wish that

I could be helped to be
Signature: able to lose weight
as this depresses me.

6. Current emo-
tions: ... and
how do you feel
about that now?

7. Holistic con-
tent: ...and what
does all of that
mean for you?

8. Holistic con-
text: ...and what
does that say
about you as a
person?

9. Needs, wants,
wishes: ...and
what do you
hope would be
done about that?

10. Expectations.
...and what do
you think we
can do for you
here on the
ward?

0 - 10
 0 - no problem
 10 - worst

- ♦ List person's main problems/needs
- ♦ Check wording with person
- ♦ Enter rating for each problem/need

Distress

Disturbance

Control

Voices, help to control voices

8

8

10
(None)

Feeling of self-harm

8

9

7

Weight problem, it stresses me a lot

7

9

5

Tidal Model Tidal Model Tidal Model

Signed:

Date:

The people who are important:

my mother and her partner
Mary also my big brother,
my papa my best friend Stacy
also my cousins Laim and Ceran
'my aunts Caram and my step
gran dot because they help
me

The things that are important:

The things that are important to
me are my home my teddies

The ideas about life that are important :

None

Personal Resources

Ask the person to describe the personal assets or resources, which might help in the resolution of the problem.

1. Who is important in your life - e.g. family, friends, groups, other people? Why are they important?

2. What is important in your life - home, money, possessions etc? Why are they important?

3. What are your beliefs about life in general - faith, personal philosophy, values?

Signature:

Pura Lushy

How will I know the problem has been solved, or the need has been met?

Better relationship with my muna.
Being able to do school-work and stuff.
Much happier, like myself.

Resolution of Need or Problem Solution

Ask the person to describe what it would be like to be without the problem, or to have their need met.

1. *How will you know when this need has been met, or this problem has been solved?*

Give me an example of how things will be 'different'.

2. *What needs to change to allow this to happen?*

How will this change show itself - in you, other people, any other aspect of your everyday life?

What needs to change for this to happen?

The way I think, I think I'm worthless and things like that. I should stop believing what the voices say. The eating and the weight are a very big thing for me. I'd like a structured eating plan. I'd like to see a dietitian as well.

Signature:

Nurse's Global Assessment of Suicide Risk

Name DOA

Assessing Nurse Date.....

- | | | |
|--------------------------|-----|---|
| ☐ | 1. | Presence/influence of hopelessness (3) |
| ☐ | 2. | Recent stressful event (e.g. job loss, financial worries, pending court action) |
| ☐ | 3. | Evidence of persecutory voices/beliefs |
| ☐ | 4. | Evidence of depression / loss of interest or loss of pleasure (3) |
| ☐ | 5. | Evidence of withdrawal |
| ☐ | 6. | Warning of suicidal intent |
| ☐ | 7. | Evidence of plan to commit suicide (3) |
| ☐ | 8. | Family history of serious psychiatric problems or suicide |
| ☐ | 9. | Recent bereavement or relationship breakdown (3) |
| ☐ | 10. | History of psychosis |
| ☐ | 11. | Widow / widower |
| ☐ | 12. | Prior suicide attempt (3) |
| ☐ | 13. | History of socio-economic deprivation |
| ☐ | 14. | History of alcohol or substance abuse |
| ☐ | 15. | Presence of terminal illness |

Total Score:

Engagement Level Indicated

The Monitoring Assessment Record

♦ *Feelings*

sad, upset, lonely, scared

♦ *Safety*

(0 vulnerable/ 10 safe)

5

♦ *Possible Help*

Don't know, I really don't know

♦ *Risk of harm* (0 no chance/ 10 very definite)

8

♦ *Support to reduce risk* (0 no chance/ 10 very good chance)

8

♦ *Suggestions for helpfulness*

maybe exercise would help
Distraction doing something
different help

Confidence Rating (0 none/10 very confident)

Person

3

Nurse

5

Signatures:

Date: 24.7.05

Security Plan

What can I do that might help to deal with your present problems?

What help can others offer that I might find valuable?

Just support me, being taken out of a situation that scares me.

I can come and ~~the~~^{error} tell staff.

Emma - To approach staff when feeling unsafe.

Staff - To offer support, by using distraction and engagement in other activities.

Signature

Date

 24.7.05

Signature

Date

24.7.05.

Final to be retained by client/patient. A copy to be filed in nursing notes.

GLASGOW ADOLESCENT RISK SCREEN (PILOT VERSION)

Patient: <u>Emma Lindsay</u>	DOB: <u>26/8/90</u>
Context of Assessment: On admission ☒ MDT Review ☐ Emergency review ☐ On discharge ☐	
CPA review ☐ Annual update ☐ Other ☐	

- A. This generic risk screen should form an integral part of a comprehensive mental health assessment and care planning process.
 B. This is not an exhaustive list of safety issues/risk factors. It is merely intended to provide an initial indicator of the potential source of risk, and hence inform clinical management.
 C. The expectation that all safety risks can be predicted is unrealistic, and assessment can only be based on information available.
 D. If completed by one person (e.g. out of hours), this assessment should be discussed as soon as is practicable with the multi-disciplinary team (inc. users and carers where appropriate).

Rating Guidance – Place a tick in those items where there is evidence that the risk factor is present, also refer to guidance notes (note that protective factors are associated with reduced risk)

Suicide or Self Harm	Violence	Other Risk
HISTORICAL OR STABLE RISK FACTORS		
1. Any previous self harm or suicide attempt ☒	1. Previous Violence ☐	1. Sexual aggression or offending. ☐
2. Self harm or suicide behaviour in the last year. ☒	2. Early onset of violence (under 12) ☐	2. Repeated fire-setting ☐
3. Previous substance misuse ☐	3. History of impulsive and risk taking behaviour. ☐	3. Confusion or disorientation ☐
4. Depressive, anxiety or conduct problems. ☒	4. Parental violence ☐	4. Difficulty communicating needs ☐
5. History of impulsive and risk taking behaviour ☒	5. History of non-violent offending or antisocial behaviour. ☒	5. Currently vulnerable to exploitation, abuse or neglect. ☐
6. Childhood adversity. ☒	6. Previous substance misuse ☐	6. Socially or culturally isolated. ☐
7. Family members with a history of suicidal behaviour ☐	7. Educational problems. ☐	7. Risk to physical health e.g. weight loss. ☒
8. More than 5 stressful life events ☐	8. Childhood adversity ☒	
	9. Any previous assault on authority figures. ☐	
CURRENT DYNAMIC RISK FACTORS	CURRENT/DYNAMIC RISK FACTORS	
9. Suicidal ideation or threats ☐	10. No concern about victims ☐	
10. Suicidal planning ☐	11. Antisocial gang memberships ☐	
11. Access to suicidal methods ☐	12. Limited leisure activities or personal interests ☐	
12. Difficulty dealing with everyday problems ☒	13. Violent thoughts ☐	
13. Few reasons for living. ☐	14. Lack of concern about consequences of actions for themselves. ☐	
14. Current low mood, severe anxiety or agitation. ☐	15. Weapon carrying ☐	
15. Recent major life event, loss or stressor. ☒	16. Escalating frequency and severity of violent behaviour. ☐	
16. Paranoid, command or other psychotic symptom associated with suicide. ☒	17. Substance misuse. ☐	
PROTECTIVE FACTORS	18. Few realistic plans for the future. ☐	
	19. Poor anger control ☒	
17. Level of service involvement. ☒	20. Paranoid, command or other psychotic symptom, associated with violence. ☐	
18. Positive engagement with risk management group. ☒	PROTECTIVE FACTORS	
19. Good social or family supports. ☒		
	21. Level of service involvement ☒	
	22. Level of engagement with risk management package. ☐	
	23. Good social or family supports. ☒	
	24. Any pro-social activity. ☒	

Summary Formulation

(Include history, current key risk factors identified for violence/suicide/self harm or other risk, include factors maintaining risk)

14 yr old ♀ with long hx of behavioural difficulties at home + school. Background hx of parental mental illness (mg SCZ) and fairly recent parental bereavement.

Long hx of internal voices → 6/12 ago took impulsive OD (sought help after) to help cope with voices. Repeated superficial self harm to arms/legs used as coping mechanism.

Dysthymia - no biological signs of depression.

Risk Management Strategies

(Target dynamic and maintaining factors)

Maintain factors for risk identified	Detail of Intervention/Treatment	Led by (Name)
DELIBERATE SELF HARM	MONITOR MENTAL STATE AND IDEAS OF DSH. ENCOURAGE ALTERNATIVES	MDT
RISK OF AGGRESSION	VE - ESCALATION BY N/S THEN PRN MEDICATION	MDT
RISK OF BINGEING + VOMITING	NURSING INTERVENTIONS	MDT/NURSES
RISK OF WEIGHT GAIN	REVIEWING MEDICATION	MDT/MEDICS
RISK OF EDUCATIONAL UNDER-ACHIEVEMENT	ENCOURAGE TO ATTEND UNIT SCHOOL	MDT
Risk of inappropriate sexual contact with male peers	monitor contact, keep under regular obs	MDT/nurses

Date of Assessment: 19/7/05	Date of Review: 22/07/05	Named Nurse: AL
Legal Status: Informal ☒ Detained ☐	RMO:	
Involved in risk assessment:		
Patient ☐	Carer ☐	Consultant Psychiatrist ☒ <i>SAR</i>
Clinical Psychology ☐	Teacher ☐	Parry-Jones ☐
		Dietician ☐ Ward Nurse ☐ SW ☐ OT ☐
Completed by (Sign): <i>[Signature]</i>		Print Name: {

Weekly MDT Up-date

In the event that there has been no change in the weekly Risk assessment up-date. Please sign and date one of the additional boxes below.

If there is any changed to the risk assessment a new assessment form should always be completed.

Date of Assessment: 22/07/05	Date of Review: 29/07/05	Key Worker:
Legal Status: Informal ☒ Detained ☐	Case Manager:	
Involved in risk assessment:		
Patient ☐	Carer ☐	Consultant Psychiatrist ☐ <i>SPR</i>
Clinical Psychology ☐	Teacher ☐	Parry-Jones ☐ <i>Staff Grade Doctor</i>
		Dietician ☐ Ward Nurse ☐ SW ☐ OT ☐
Completed by (Sign): <i>[Signature]</i>		Print Name:

Date of Assessment: 29/7/05	Date of Review: 5/8/05	Key Worker:
Legal Status: Informal ☒ Detained ☐	Case Manager:	
Involved in risk assessment:		
Patient ☐	Carer ☐	Consultant Psychiatrist ☒ <i>TRAINER</i>
Clinical Psychology ☐	Teacher ☐	Parry-Jones ☐
		Dietician ☐ Ward Nurse ☒ SW ☐ OT ☐
Completed by (Sign): <i>[Signature]</i>		Print Name:

Date of Assessment: 5/8/05	Date of Review: 12/8/05	Named Nurse:
Legal Status: Informal ☒ Detained ☐	RMO: T	
Involved in risk assessment:		
Patient ☐ Carer ☐ Consultant Psychiatrist ☒ Dietician ☐ Ward Nurse ☒ SW ☐ OT ☐		
Clinical Psychology ☐ Teacher ☐ Parry-Jones ☐		
Completed by (Sign):		Print Name:

Weekly MDT Up-date

In the event that there has been no change in the weekly Risk assessment up-date. Please sign and date one of the additional boxes below.

If there is any change to the risk assessment a new assessment form should always be completed.

Date of Assessment: 12/8/05	Date of Review: 19/8/05	Key Worker:
Legal Status: Informal ☒ Detained ☐	Case Manager:	
Involved in risk assessment:		
Patient ☐ Carer ☐ Consultant Psychiatrist ☐ Dietician ☐ Ward Nurse ☒ SW ☐ OT ☐		
Clinical Psychology ☐ Teacher ☐ Parry-Jones ☐		
Completed by (Sign):		Print Name:

Date of Assessment: 19/8/05	Date of Review: 26-8-05	Key Worker:
Legal Status: Informal ☒ Detained ☐	Case Manager:	
Involved in risk assessment:		
Patient ☐ Carer ☐ Consultant Psychiatrist ☐ Dietician ☐ Ward Nurse ☒ SW ☐ OT ☐		
Clinical Psychology ☐ Teacher ☐ Parry-Jones ☐ Other Dr ☒		
Completed by (Sign):		Print Name:

26/8/5

2/9/5

Date of Assessment: 9/9/05	Date of Review: 13/9/05	Named Nurse:
Legal Status: Informal ☒ Detained ☐		RMO: DR
Involved in risk assessment:		
Patient ☐	Carer ☐	Consultant Psychiatrist ☐ Dietician ☐ Ward Nurse ☒ SW ☐ OT ☐
Clinical Psychology ☐	Teacher ☐	Parry-Jones ☐
Completed by (Sign):		Print Name:

Weekly MDT Up-date

In the event that there has been no change in the weekly Risk assessment up-date. Please sign and date one of the additional boxes below.

If there is any change to the risk assessment a new assessment form should always be completed.

Date of Assessment: 16/9/05	Date of Review: 23/9/05	Key Worker:
Legal Status: Informal ☒ Detained ☐		Case Manager: DR
Involved in risk assessment:		
Patient ☐	Carer ☐	Consultant Psychiatrist ☐ Dietician ☐ Ward Nurse ☐ SW ☐ OT ☐
Clinical Psychology ☐	Teacher ☐	Parry-Jones ☐ SPR ☒
Completed by (Sign):		Print Name:

Date of Assessment: 14/10/05	Date of Review: 18/10/05	Key Worker:
Legal Status: Informal ☒ Detained ☐		Case Manager: DR
Involved in risk assessment:		
Patient ☐	Carer ☐	Consultant Psychiatrist ☐ Dietician ☐ Ward Nurse ☒ SW ☐ OT ☐
Clinical Psychology ☐	Teacher ☐	Parry-Jones ☐
Completed by (Sign):		Print Name:

Divisional Headquarters
Gartnavel Royal Hospital
1055 Great Western Road
GLASGOW G12 0VT
Telephone
www.nhsgg.org.uk



Date of Assessment: 16/10/05		Date of Review: 24/10/05	Named Nurse:
Legal Status: Informal ☐ Detained ☐		RMO:	
Involved in risk assessment:			
Patient ☐	Carer ☐	Consultant Psychiatrist ☐	Dietician ☐ Ward Nurse ☒ SW ☐ OT ☐
Clinical Psychology ☐	Teacher ☐	Parry-Jones ☐	
Completed by (Sign):		Print Name:	

Weekly MDT Up-date

In the event that there has been no change in the weekly Risk assessment up-date. Please sign and date one of the additional boxes below.

If there is any change to the risk assessment a new assessment form should always be completed.

Date of Assessment: 25/10/05		Date of Review:	Key Worker:
Legal Status: Informal ☒ Detained ☐		Case Manager: DV	
Involved in risk assessment:			
Patient ☐	Carer ☐	Consultant Psychiatrist ☐	Dietician ☐ Ward Nurse ☒ SW ☐ OT ☐
Clinical Psychology ☐	Teacher ☐	Parry-Jones ☐	
Completed by (Sign):		Print Name:	

Date of Assessment:		Date of Review:	Key Worker:
Legal Status: Informal ☐ Detained ☐		Case Manager:	
Involved in risk assessment:			
Patient ☐	Carer ☐	Consultant Psychiatrist ☐	Dietician ☐ Ward Nurse ☐ SW ☐ OT ☐
Clinical Psychology ☐	Teacher ☐	Parry-Jones ☐	
Completed by (Sign):		Print Name:	