UPDATE

To be used if full Single Shared assessment has been completed within the last 2 years

Drug / Alcohol Support Needs Assessment Package

Person's Name: Agnes McLaughlan.

Person's DOB: 9/11/70

Lead Assessor's Name: Patricia Cunn.

Agency of Lead Assessor: ADC

Date of Assessment: 10/9/08.

Date of Review:

Date of Review:

Date of Review:

Date of Review:

Section 1: Basic Information

Person's Full Name:	Agnes McNaught	CRI / PIMS Number:	3241
Assessor's Name:	P. Cunn	SWIFT Number/Care first: Reference Number:	
Agency:	APC	Consent Form Completed:	YES ☒ NO ☐
Contact Details /Tel:	314 4106	Date of Assessment:	10/9/8
Location (where seen):	Dykebar	Date of Birth:	9/11/70

Section 2: ALCOHOL / DRUG CURRENT USE & Use since last assessment

Drugs / Alcohol History: short history since last assessment leading to present use (present use should be more detailed). Indicate type of substance (legal (L), illegal (I) or prescribed (P) Method of use

Age	Substance Used	Type (L, I or P)	Consequences
38.	Relapse for 2 months June – August 10 can of Stella (lager)		low mood - Stopped Antabuse. [redacted]

Have you ever injected?	YES		NO		
Have you ever shared injecting equipment?	YES		NO		

Comments - relating to above

Section 3: SERVICE HISTORY DETAILS

Confirm that service history you have on file is accurate Yes NO

If No please record below relevant history

Section 4: GENERAL INFORMATION / PROFILE

If information changed from last assessment please indicate

HOUSING (Tenancy, Problems, Complaints, Arrears, length of Tenure)

changed since last assessment: Yes NO

Awaiting more from flat. S.W dept dealing with this.

FINANCE (Present Income, Outgoings and Debts)

changed since last assessment: Yes NO

Income Maximization required? Yes No N/A

Employment Past/current difficulties, literacy and numeracy

changed since last assessment: Yes NO

EDUCATION (Past / Current Difficulties, Literacy and Numeracy)

changed since last assessment: Yes NO

CURRENT LEGAL STATUS

Please indicate status below.

☑ None	☐ Probation	☐ Licence	☐ DTTO
☐ DTTO assessment	☐ Community Service	☐ In Prison	Other ☐

Details:

Previous Offences:
changed since last assessment: Yes NO

Current / Outstanding Offences:
changed since last assessment: Yes NO

Any other details (including any periods in prison)

Section 5: HEALTH INFORMATION / PROFILE

GP Details

Name: Dr McMulla **Telephone:** _____

Address: Anchor Mill MC. **Fax:** _____

_____ **E-mail:** _____

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

changed since last assessment: Yes NO

Psychological Health (including hospital admissions and current prescribed medication)

changed since last assessment: Yes NO

Section 6: SOCIAL SITUATION / CONTEXT

Brief summary of service user lifestyle and social context, relationships – this should set the scene for moving on to childcare area. Include partner name and address and whether or not partner is a drug/alcohol user.

changed since last assessment Yes NO

Section 8: ASSESSMENT OUTCOME / PLAN OF CARE

Identified Need *(Should be in order of priority of user)*	**Proposed Interventions** *(Demonstrate how intervention will take account of gender, ethnicity and disability)*	**Timescale** *(Include person responsible)*
Assistance to stay alcohol free	Group prog. Antabuse work-up.	1 day.

Unmet Need	**Reasons**

Client's Perception of the Above

Needs to stay sober to keep kids [redacted]

Please identify any factors related to children's issues arising from assessment

Section 7: INFORMATION ON CHILDREN & OTHER CARE RESPONSIBILITIES *(continued)*

Relatives / Other Agencies Arranging Childcare: Yes ☑ No ☐ N/A ☐

Details: Family Matters - Annette Turner (Home Link)

Help Required with Children or Arranging Childcare: Yes ☐ No ☐ N/A ☐

Details:

Social Worker: Yes ☑ No ☐ N/A ☐

Details: Andrew Nelson
Kelvin Hoe - Tel 342 5157.

Health Visitor: Yes ☑ No ☐ N/A ☐

Details: Laura McKinnon - Anchor Mill Med. Practice

Children's Health Issues: Yes ☑ No ☐ N/A ☐

Details: [redacted] - heart murmur + Stent.

Progress at School / Nursery Yes ☐ No ☐ N/A ☐

Details:

Client's Perceived Effects of His / Her Own Alcohol / Drug Use on Children
Please include perceived effects of any other alcohol and drug use on client's children.

Affects Lyan but not 2 other children.

What arrangements are made for children when drug / alcohol use is being pursued / consumed?

"She manages"

What arrangements are made for safe storage of alcohol / drugs (both illegal and prescribed)?

In the fridge. "Kids won't touch".

Section 8: ASSESSMENT OUTCOME / PLAN OF CARE *(continued)*

FURTHER ASSESSMENT INDICATED

Please check relevant boxes and give details of service / agency.

Alcohol Detoxification:	Inpatient	☐	Residential Rehabilitation	☐
	Outpatient	☐	Other	☐
	Home Detox	☐		
	Residential Detox	☐		

Agency / Service Details

SUMMARY OF ASSESSMENT

- Group programme
- Antabuse Therapy
- liaise with SW Dept.

NO FURTHER ACTION

Please give details why.

Service User's Signature: **Date:** 10/9/18

Assessor's Signature: P. Cura **Date:** 10/9/18

Renfrewshire Joint Care

Partnership

Shared Information

Client Details

Surname: McLaughlan	**Date of Birth:** 9.11.70.
Forename: Agnes	**Social Work ID:**
Contact Agency: APC	**Department:**

I Mr/Mrs/Ms Miss Agnes McLaughlan have had the principles of joint care planning explained to me by my ~~health~~/social worker.

Melanie Kita. I understand that it may be necessary for information relating to me to be shared between the various agencies involved in my care, i.e.. health and social work professionals and voluntary agency staff. Where appropriate. The information shared will only be that relevant to my care and it will be only on a "need to know " basis.

- **I give** my consent to the sharing of my personal information for the joint care planning purposes explained to me.
- **I give** restricted consent to the sharing of my personal information for the joint care planning purposes explained to m
- **I do not give** my consent to the sharing of my personal information for the purposes explained to me and I understand that this could place restrictions on the integrated service within my care plan. These restrictions have been explained to me.

I * have/have not received a copy of an information leaflet which explains how information about me is used.

**Please delete as appropriate*

Signed A. McLaughlan Date 14/8/07

Status if not client: _____

Health/Social Worker Statement:

I confirm that I have explained to Agnes McLaughlan the principles of joint care planning, including the fact that information may be shared with others on a "need to know" basis. I have also explained that should information sharing consent be refused the level of integrated service cc restricted.

Signed Melanie Kita. Date 14.08.07.

Designation SW

Client Signature:	Worker Signature:	Additional Information:	Date:

Person's full name :
Mr / Mrs / (Miss) / Ms / Other Agnes MacLaughlan.
Preferred name :
DOB : 9 / 11 / 1970
Lives alone – Yes / No (please circle)

CHI number : 3241
Social work number : 9053299
Other number *(specify)* :
Gender : M / (F)
Ethnic Background : White British

Referrer
Name of Referrer : Margaret Graham.
Address :

Profession
Telephone :

Is person aware that referral has been made? (Yes) / No (please circle)

Reason for assessment

Date of referral : ____ / ____ / ____

Long-standing alcohol problem. Recently detoxed self independently but requires ongoing support.

Person lives in? *(tick box)*

Rented – Local Authority	☐	Sheltered Housing	☐	Residential Home – Local Authont	
Rented – Housing Assoc.	☑	Supported accommodation	☐	Residential Home – Private	
Rented – Private Landlord	☐	Hospital	☐	Residential Home – Voluntary	
Rented – Other (specify what)	☐	Nursing Home	☐	Hostel	
Privately Owned	☐	Care Home	☐	Homeless	
Relatives home (specify who)	☐	Other (specify what)	☐		

Present address : 3/6 36 McKerrell St.
Post town : Paisley
Post code : PA1 1NN.
Telephone : (0141) 561 0710.

Home address *(if different)* :
Post town :
Post code :
Telephone :

Contact Details	Main carer	Next of Kin (if different)	Keyholder (if dif
Name (include title) :		Fulton Kerr	
Relationship to person :		Children's Father.	None.
Keyholder :	**Yes / No** *(circle)*	**Yes / (No)** *(circle)*	
Address :		[redacted]	
Post town :		[redacted]	
Post code :			
Tel (Day) :			
Tel (Night) :			
Tel (Mobile) :			

Who is the GP? Dr. S. McCormick

Address: 8 Incle St.
Paisley

Post town : PA1 1HP.

Post code :

Tel (Day) : (0141) 889 8809.

Tel (Night) :

Practice number :

Communication Needs

Preferred language :

Is an interpreter required? Yes / No *(circle)*

Sign Language required ? Yes / No *(circle)*

Hearing aid used? (Yes) / No *(circle)* Doesn't wear it

Spectacles used? Yes / (No) *(circle)*

Other - please specify

Relevant Background History

To include where appropriate : *Work/employment, Family, Marital Status, Religion, Any other factors – Housing/Accommodation issues, recent change in abilities/function, Concerns, Risks, Social network, Bereavement,*

Agnes left school at 15 and has never worked, but is currently considering undertaking some form of ed./training. She is single and has 3 children aged 6, 4 and 20 months, respectively.

Both Agnes' parents had alcohol problems and she spent a great deal of her childhood in and out of local authority care. Agnes currently receives support from Comm. Care SW Carol Gallagher, P.A.T. She previously attended the APC at the ages of 22 and 25, but did not manage to achieve abstinence. She began to receive support from RCA in July '07 and has now been abstinent for 4 weeks. She is now keen to receive additional support to help her remain abstinent.

Relevant Medical History (including current medical conditions and medication)

No current health problems.

Current meds - Lofepramine 70mg x 2 daily.

Previous history of ~~medic~~ MR liver problems.

3 previous admissions (RAH) due to alcohol excess; Agnes unable to remember dates - none over past 2 years however.

Single Shared Assessment

Drug / Alcohol Support Needs Assessment Package

15 November 2006: Version 9

Person's Name:	Agnes Mclaughlan
Person's DOB:	9·11·70
Lead Assessor's Name:	Melanie Klita
Agency of Lead Assessor:	APC / SW.
Date of Assessment:	14·08·07.
Date of Review:	
Date of Review:	
Date of Review:	

Section 1: BASIC INFORMATION

Person's Full Name:	Agnes McLaughlan	CHI / PIMS Number:	3241
ADDRESS		SWIFT/CARE FIRST/REFERENCE Number:	
GP NAME, ADDRESS AND TEL NUMBER	Dr Stewart McCormick 8 Inde St Paisley PA1 1HP.	Date Consent Form Completed:	
Location (where seen):	APC	Date of Birth:	9.11.70

Section 2: ALCOHOL / DRUG CURRENT USE & HISTORY

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

Current

Substance Used (What, How much, How often, and Last used)	Type (L, I or P)	Consequences
No alcohol for 4 weeks; detoxed independently of any treatment / support. Prior to this was drinking 15 cans lager per day. Breathalyzed 0. No recent drug use.	L	Shaking, sweating, itching, nausea + vomiting, anxiety. Didn't sleep well, no appetite. No seizures / DT's.

Have you ever injected?	YES		(NO)	X	
Have you ever shared injecting equipment?	YES		NO		

Comments – relating to above

Section 2: ALCOHOL / DRUG CURRENT USE & HISTORY (contd)			
History			
Age	Substance Used (What, How much, How Often)	Type (Legal,illegal or prescribed)	Consequences
12	Solvent abuse, daily.		
15	Stopped glue-sniffing + began drinking; 1 litre cider daily.		Vomitting in the mornings - no other withdrawal symptoms.
17	Began drinking vodka - 1 litre per day.		
18	Left SW care + began drinking mae - vodka and lager. Can't remember quantities.		
20	Moved in with friend and began drinking all different kinds of drinks; again unable to state quantities.		
22	Attended APC as outpatient, briefly.		
25/26	Attended APC but did not achieve total abstinence.		Began to experience shaking, sweating, anxiety.
30	Had first child and alcohol use began to decrease. 6 cans lager daily.		
34-36	Drinking increased again, to current levels.		

Section 3: SERVICE HISTORY DETAILS	Yes	No	N/A
Current and Previously Known Details: Please indicate whether client has any other current involvement, and whether s/he is previously known to this agency and / or other agencies			

Contact Details Named Worker (address & telephone) Dates of Involvement	Interventions	Outcomes (please include dates)
Margaret Graham, RCA. Since July '04.		
Carol Gallagher, SW. Paisley Area Team.	Sees Carol weekly.	
Christine Duffy (Educ & Leisure) Abbey Hse	+ve parenting	Tel 840 3807

Section 4: GENERAL INFORMATION / PROFILE									
HOUSING (Tenancy, Problems, Complaints, Arrears, Length of Tenure)						(Yes)		No	N/A
Details: In current tenancy for 6 years. Has applied for another house as has difficulty with stairs.									
FIRE RISK: Information given	YES	NO	**Leaflet Given**	YES	NO	**Referral On**	YES	NO	DECLINED
FINANCE (Present Income, Outgoings and Debts)						(Yes)		No	N/A
Details: Income support, child benefit. No debts.									
Income Maximisation Required?						Yes		No	N/A
EMPLOYMENT (Past/Current Difficulties, Literacy and Numeracy)						Yes		No	N/A
Details: Has never worked.									
EDUCATION (Past/Current Difficulties, Literacy and Numeracy)						Yes		No	N/A
Details: Currently considering training. Left school at 15 - had been playing truant. Literate + numerate.									
CURRENT LEGAL STATUS (Please indicate status below)						Yes		No	(N/A)
None			Probation			Licence		DTTO	
Community			In Prison			Other		DTTO Assessment	
Details: No legal history.									
Previous Offences:						Yes		No	(N/A)
None.									
Current / Outstanding Offences						Yes		No	(N/A)
None									
Any Other Details (including any periods in Prison)									

Section 5: HEALTH INFORMATION / PROFILE

Physical Health (including hospital admissions, current prescribed medication, Hepatitis B vaccination, Hepatitis C information, Pregnancy).

Smoker (Y)/N If yes How many 15 per day.

Previous history of liver problems.

3 previous admissions (RAH) – alcohol excess. Can't remember dates; none over past 2 years.

Current meds – Lofepramine 70mg twice daily.

No vitamins.

Psychological Health (including hospital admissions and current prescribed medication).

Agnes has been known to Psychiatric services since age 15, although no involvement since adolescence.

Attended APC in mid 20's.

No admissions, no medication.

Section 6: SOCIAL SITUATION / CONTEXT
Living / Domestic Arrangements; Family Relationships (Past and Present); Current/history of domestic violence
Current
Currently lives with her children. 2 sisters reside nearby but Agnes tries not to see them as they both use alcohol. Mum is currently in a care home. Agnes is on good terms with her ex-partner, who still visits to see the children. He has been abstinent for 7 years.
Past
Parents had alcohol problems; her father died when she was aged 1, following a domestic incident. Agnes was accommodated by the local authority at the age of 12, having spent periods in + out of SW care since the age of 1. She left care at the age of 18.

Section 8: ASSESSMENT OUTCOME / INITIAL PLAN OF CARE		
Identified Need (Should be in order of priority of user)	**Proposed Interventions** (Demonstrate how intervention will take account of gender, enthicity and disability)	**Timescale** Include person responsible
Ongoing support to maintain abstinence.	Attendance at Groupwork Programme. Wk. beginning 3/9/07. ? Antabuse - Agnes considering this.	

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

Youngest child [redacted] currently attends nursery from 1pm - 3.45pm, 5 days per week. His hours will need to be increased / altered if Agnes is to be able to attend the Group Programme; this will be addressed.

Section 8: ASSESSMENT OUTCOME / INITIAL PLAN OF CARE (contd)

Summary of Assessment

Agnes is 37 years dd and has 3 young children. She has been drinking heavily since the age d 15 and had been drinking at a dependent level until recently. She became involved with Margaret Graham at RCA in July '07 and has now been abstinent for 4 weeks. She is seeking further support to maintain abstinence and will be admitted into the ARC on 3·09·07.

Unmet Need	N/A	Reasons

Client's Perception of the Above

Agnes is keen to attend Groups but has some childcare issues, to be addressed by assessor.
She is considering antabuse therapy.

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

Service Users Signature: A. McLaughlan — Date 14·08·07

Assessors Signature: Melanie Keir — Date 14·08·07.

Mental Health & Learning Disabilities

Source: Sainsbury Centre for Mental Health

RISK ASSESSMENT AND MANAGEMENT (LEVEL 1)

CLIENT NAME: Agnes Mclaughlan D.O.B.: 9 / 11 / 70 ID No: 3241

ADDRESS: 31, 36 Mcrenell St., Paisley POSTCODE: PA1 1NN

DATE/PERIOD OF ASSESSMENT: / / TIME:..... REVIEW DATE: / /

RISK FROM OTHERS (eg. Abuse, exploitation) — YES /NO — UNKNOWN
Details of identified risk: Further investigation required*

No known history; presents as vulnerable however.

RISK TO SELF (eg. Suicide, self harm) — YES / NO — UNKNOWN
Details of identified risk: Further investigation required*

No known history of suicidal ideas / self harm.

RISK TO OTHERS (eg. Aggression, violence) — YES / NO — UNKNOWN
Details of identified risk: Further investigation required*

No known history of aggressive/violent behaviour.

RISK OF NEGLECT (eg. Health, personal) — YES / NO — UNKNOWN
Details of identified risk: Further investigation required*

Neglects own health when drinking.

RISK TO CHILD(REN) (eg. Neglect, abuse) — YES / NO — UNKNOWN
Details of identified risk: Further investigation required*

Possible if Agnes were to drink to intoxication while caring for the children.

RISK OF PHYSICAL IMPAIRMENT (eg. Medical, sensory) — YES / NO — UNKNOWN
Details of identified risk: Further investigation required*

With continued alcohol misuse.

RISK OF WANDERING and/or FALLS — YES / NO — UNKNOWN
Details of identified risk: Further investigation required*

With continued alcohol misuse.

MEMORY & COGNITIVE IMPAIRMENT — YES/NO — UNKNOWN
(eg. Forgetfulness) Further investigation required*
Details of identified risk: With continued alcohol misuse.

CHALLENGES TO SERVICES — YES / NO — UNKNOWN
(eg. Inappropriate demands, poor service response) Further investigation required*
Details of identified risk:

None known.

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

SIGNIFICANT KNOWN HISTORY (including known diagnoses):

Previous hospital admissions due to alcohol excess.
Daily drinking (with some brief periods of abstinence) since the age of 15.
Previous history of alcohol-related seizures; no DTs.
Currently abstinent for 4 weeks.

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

Risk of seizures on withdrawal.

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

Agnes has been abstinent for 4 weeks and is no longer experiencing withdrawal symptoms.
Attendance at Groupwork Programme and possible antabuse therapy thereafter.

SOURCES OF INFORMATION : AVAILABLE

Client; case-records.

CONTEXT OF CLIENT FOR ASSESSMENT

APC.

ROLE OF CLIENT and/or CARER IN PLAN:

CLIENT INVOLVED: (YES) / NO **CARER INVOLVED:** YES / NO

CLIENT AGREED: (YES) / NO **CARER AGREED:** YES / NO

COMMENTS:

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

Recorded by: M. Khan **Date:** 14.08.07

Discussed with: **Time:**

SEVERITY OF ALCOHOL DEPENDENCE QUESTIONAIRE

NAME Agnes McLaughlan CHI NO 3241

Please recall a typical period of heavy drinking in the last 6 months.

When was this? Month Jan Year 2007

Please put a tick ( ) to show how often each of the following statements applied to you during this time.

DURING THAT PERIOD OF HEAVY DRINKING	NEVER OR ALMOST NEVER	SOME-TIMES	OFTEN	NEARLY ALWAYS
1. I woke up feeling sweaty.	☐	☑	☐	☐
2. My hands shook first thing in the morning.	☐	☐	☐	☑
3. My whole body shook violently first thing in the morning if I didn't have a drink.	☐	☐	☐	☑
4. I woke up absolutely drenched in sweat.	☐	☑	☐	☐
5. I dreaded waking up in the morning.	☐	☐	☑	☐
6. I was frightened of meeting people first thing in the morning.	☐	☐	☐	☑
7. I felt at the edge of despair when I awoke.	☐	☑	☐	☐
8. I felt very frightened when I awoke.	☐	☑	☐	☐
9. I liked to have a morning drink.	☐	☐	☐	☑
10. I always gulped my first few morning drinks down as quickly as possible.	☐	☐	☐	☑
11. I drank in the morning to get rid of the shakes.	☐	☐	☐	☑
12. I had a strong craving for drink when I awoke.	☐	☐	☐	☑
13. I drank more than ¼ bottle spirits a day (or 4 pints beer / 2 cans strong lager / 1 bottle table wine).	☐	☐	☐	☑
14. I drank more than ½ bottle spirits a day (or 8 pints beer / 4 cans strong lager / 2 bottles table wine).	☐	☐	☐	☑
15. I drank more than 1 bottle spirits a day (or 15 pints beer / 8 cans strong lager / 4 bottles table wine).	☐	☐	☐	☑
16. I drank more than 2 bottles spirits a day(or 30 pints beer / 15 cans strong lager / 8 bottles table wine).	☐	☑	☐	☐

PLEASE MAKE SURE YOU HAVE ANSWERED ALL THE QUESTIONS WHICH APPLY TO YOU.

PLEASE TURN PAGE.

Imagine the following situation

(1) You have been COMPLETELY off drink for the past FEW WEEKS.

(2) You then drink VERY HEAVILY for TWO DAYS.

How would you feel the morning after those two days of heavy drinking?

THE MORNING AFTER	NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A LOT
17. I would start to sweat.	☐	☐	☐	☑
18. My hands would shake.	☐	☐	☐	☑
19. My body would shake.	☐	☐	☐	☑
20. I would be craving for a drink.	☐	☐	☐	☑

TOTAL SCORE ☐☐

Name

CLINICAL NOTES

Ward

DATE	
23/12	Phone call received from Mgt Graham @ RCA. Agnes located and is well. Problems at home had resulted in her leaving home. She has returned home and has agreed to continue with RCA Trust. D.L. Carl
21/1/9	Review - sister currently in hospital [redacted] and very unwell - may not survive - agnes very low in mood & appetite, sleep 3 hrs nightly - has separated from husband recently went missing for 4 days after last appt - stayed with friend as husband verbally abusive - now she lives with her children [redacted] - no suicidal thoughts - has appt to see GP tomorrow - has not yet had ↑ antidepressants - no relapse to drinking P/L prescription given to ↑ Citalopram to 60mg p.d.v. 4 wks to see if any response however when comes to RCA and at AVC and will continue to do so J. Lloyd

CLINICAL NOTES

DATE	
13/7/9	SCS [illegible] OPA / APC CC→PA
	- DNA
	- ×1 [illegible] OPA the [illegible] discharge
	[illegible] SCS
14/6/10	Attended APC
	×3 [illegible]
	[illegible] zoning ↑ 40 mg

STY0411D

ADMISSION RECORD PSYCHIATRY

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

HOSPITAL DYKEBAR Ward A.P.C.
Day
CONSULTANT DR. TORLEY
HOSPITAL NUMBER
DATE OF CURRENT ADMISSION Day Month Year

PATIENT

SURNAME (Block letters) ~~Mr/Mrs/Miss~~
Mc LAUGHLIN
FORENAMES
AGNES
MAIDEN SURNAME

SEX AGE DATE OF BIRTH
Day Month Year
9 11 70

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

HOME ADDRESS
7E WOODNEUK COURT
PAISLEY.
OCCUPATION ( ) UNEMPLOYED
( )

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

NATIONAL HEALTH SERVICE NUMBER

RELIGION PROT.

NEXT OF KIN

Name
ANNMARIE MEIKLE
Relationship
SISTER.
Address
S/A.
Telephone Number

NATIONAL INSURANCE NUMBER

PENSION/ALLOWANCE
Type Number
INCOME SUPPORT.

MONEY AND/OR VALUABLES LODGED Yes/No

ADMISSION DETAILS

TYPE OF ADMISSION
STATUS ON ADMISSION INF.
REFERRED TO HOSPITAL BY G.P.
MODE OF TRANSPORT
RESIDENCE IMMEDIATELY PRIOR TO ADMISSION

PREVIOUS HOSPITAL CARE
Hospital/s R.A.H.
Year/s OCT '95'

G.P.

Name of General Practitioner
DR. Mc CORMICK.
Address
INCLE STREET PAISLEY.
Telephone Number

SPECIAL WARNINGS

EPILEPSY PRESENT: Yes (No)
DIABETES PRESENT: Yes (No)
SPECIAL HAZARDS (e.g. Drug allergies, etc.)
NONE KNOWN
OTHER

CHANGE OF STATUS
Date
To

DATE OF DISCHARGE Day Month Year
To

A4N40004 2.92

ADMISSION RECORD PSYCHIATRY

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

HOSPITAL DYKEBAR Ward Day A.P.C

CONSULTANT DR TORLEY

HOSPITAL NUMBER

DATE OF CURRENT ADMISSION Day 5 Month 6 Year 96

PATIENT

SURNAME (Block letters) Mr/Mrs/Miss
McLAUGHLIN

FORENAMES
AGNES

MAIDEN SURNAME

SEX F AGE DATE OF BIRTH Day 9 Month 11 Year 70

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

HOME ADDRESS
7E, WOODNEUK COURT
PAISLEY

OCCUPATION ( )
( )

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

NATIONAL HEALTH SERVICE NUMBER

RELIGION

NEXT OF KIN

Name
ANN MARIE MEIKLE

Relationship
SISTER

Address
S/A

Telephone Number

NATIONAL INSURANCE NUMBER

PENSION/ALLOWANCE
Type Number

MONEY AND/OR VALUABLES LODGED Yes/No

ADMISSION DETAILS

TYPE OF ADMISSION

STATUS ON ADMISSION
INFORMAL

REFERRED TO HOSPITAL BY
GP

MODE OF TRANSPORT
BUS

RESIDENCE IMMEDIATELY PRIOR TO ADMISSION
HOME

PREVIOUS HOSPITAL CARE
Hospital/s R.A.H - DYKEBAR
Year/s
93

G.P.

Name of General Practitioner
DR McCORMICK

Address
IMCLE ST PAISLEY

Telephone Number

SPECIAL WARNINGS

EPILEPSY PRESENT: Yes (No)

DIABETES PRESENT: Yes (No)

SPECIAL HAZARDS (e.g. Drug allergies, etc.)
NONE KNOWN

OTHER

CHANGE OF STATUS
Date
To

DATE OF DISCHARGE Day Month Year
To

A4N40004 2.92

DYKEBAR HOSPITAL

NAME AGNES McLAUGHLIN
DATE OF BIRTH 9.11.70

CLINICAL NOTES

WARD APC
DATE 20.12.95

Admission Note
Miss McLaughlin is a 25 year old lady referred to the APC by her GP and I saw her this morning as an out-patient.
She tells me she has been an abusive drinker for the past 10 or 12 years. She was certainly drinking by the age of 15 although she first ever had a drink when she was aged about 12 or so. At present she drinks carlsberg specials and she can drink about 7 or 8 every day. This causes her to blackout and she experiences withdrawals on wakening. On two or three occasion she has experienced frank hallucinations. She was admitted to the RAH approx. 4 weeks ago and at that time in sobriety she visualised her mother lying in the bed along side her. On another occasion she had visualised spiders and cats at home. In all she tells that she has been hallucinated perhaps on 3 separate occasions all within the past year.
At not time has she ever had a fit however.
She describes herself first drinking at the age of 12. At that time she drank reasonably regularly perhaps once or twice a week. She was then established in a care home in Paisley, Beech Avenue in Hunterhill. She absconded repeatedly from this establishment but was always taken back through until the age of 16 or so. By the age f 15 she was drinking daily and from that time it has been her habit to drink carlsberg specials.
Past History/Social History
Agnes was born in Barrhead. She was taken into care at the age of 1 and she moved from several residential care centres into foster homes back and forth throughout her childhood and adolescence. Her mother is a long term patient in Ward 5 at Dykebar. She is now aged in her early 60s. She suffered a stroke and she is aphasic. She has a long past history of alcohol abuse and was certainly alcoholic at the time AGnes was born. Agnes' father died in 1971 or 1972. Agnes was approx. one year old. He died as a consequence of a fight between himself and Agnes' mother. An artery in his arm was severed during this fight and he was left lying on the floor of their home overnight and simply bled to death. He likewise was alcoholic and had been so for most of his life. He was aged about 45 when he died.
Agnes is the youngest child in a sibship of 5. She had two older brothers and two older sisters. Her oldest brother died at the age of 27 of a heart attack. Like all the members of the family he had been a chronic habitual alcoholic.
Agnes's remaining older brother, Alex, is known to the staff at Dykebar Hospital and has attended the Clinic here on several occasions. Likewise one of her older sisters was referred for detox in the past. She gives a history also that her extended family, aunts, uncles and grandparents are also likewise alcoholic.
Following the death of her father Agnes was taken into care at the age of 1. She was established in Beech Avenue even at that time for a short couple of years. She then moved into a foster home for a period of about 18 months to be taken back to Beech Avenue. At the age of 10 she moved into a further foster home for some two years to be taken back at the age of 12. She remembers the second foster home, she felt she was quite at home in Glenburn with this second family, she gives no explanation as t why she was returned to the care situation out of fostering.
Agnes was educated locally in Hunterhill or closeby the foster homes. She acquitted herself reasonably well at school. She attended regularly although towards the latter years of secondary school she truanted rather a lot. She left school at the age of 15 without any further qualification. She has not worked at any time in the interval since then. She is a spinster, never had any long term relationships, never considered marriage. At present she has given up tenancy of her own flat in Johnstone and she has moved in with her sister in the high flats close by Ferguslie. Her sister likewise is abusing alcohol daily.

Agnes denies abuse of any other illicit drugs although she does say in the past she has been prone to solvent abuse during her childhood and school years.
She has no police record of consequence. She has been lifted on several occasions for breach of the peace, usually she has been fined or admonished. She has no charges pending. SHe denies any debt problems.

Mental State

At interview this morning Agnes is clean, tidy and reasonably sober. She shows to have two facial scars running across her lips and she said these were inflicted during a fight between her parents when she was an infant. She shows to be short statured and somewhat cusheniod in her appearance. She is quietly spoken but answers frankly throughout her history taking. Her mood is appropriate, she can smile readily, she shows to have no evidence of thought disorder, memory and concentration are intact.
I have simply invited Agnes to attend the Clinic as a day patient to undergo detoxification.

Dr. McAleer/IP

DYKEBAR HOSPITAL

NAME AGNES McLAUGHLIN
DATE OF BIRTH 9.11.70

CLINICAL NOTES

WARD APC
DATE 5.6.96

Miss McLaughlin was referred back to the APC by her GP. I saw her this morning as an out-patient.
She is a 25 year old lady who has a long past history of alcohol abuse. She has had contact with the APC in the past and indeed she attended as a day patient over a period of about two weeks in December of last year.
Essentially following her discharge from day attendance she reverted to abusive drinking. Indeed my recollection is that she was drinking before she was discharged and she offers today that she felt comfortable whilst she was prescribed medication but after the medication stopped she certainly felt a sense of anxiety returning such that she wanted to revert to drink.
At present she is drinking seven or eight cans of Carlsberg Special per day. This causes her to blackout and she experiences withdrawals on wakening. She feels tense and anxious and nauseated. Typically she has a further drink as soon as she wakens and this restores her sense of equilibrium. She denies hallucinations on this occasions although this has happened in the past. She denies DTs nor has she ever had a fit.
She has a long history of alcohol abuse which started probably about 12 years ago. She started to drink at the age of 12 and she was a fairly regular drinker usually about once or twice a week being almost immediately thereafter.

Past History/ Social History

This is fully recorded in Miss McLaughlin's previous admission note dated 20.12.95 and does not bear repetition. She is a spinster, she has never had any long term relationships nor considered marriage. At present she lives with her sister in the high flats in Ferguslie, she is unemployed. She denies any debt problems and she denies any police record.

Mental State

This morning at interview Agnes shows to be clean, tidy and well presented. She is sober and she can conduct herself appropriately throughout our interview. She shows to be genuinely concerned about her drinking pattern and seems to be seriously interested in achieving sobriety. Her mood is appropriate, she shows no evidence of thought disorder, her memory and concentration are intact. Once again I have invited her to attend the Clinic as a day patient.

Dr. McAleer/IP

CLINICAL NOTES

Name AGNES McLAUGHLAN

Ward

DATE	
26.9.7	APC O/P
	"Good"
	Off alcohol for 11/52 – came off herself, ++ sweats/shakes/sick/itches/diarrhoea
	Had cravings – distracts herself – computer course & helps at nursery
	2yr old – [redacted]
	6yr – ~~Leon~~ [redacted] } doing "great"
	4yr – ~~Arran~~ [redacted] → swearing ↑↑ – has Link worker (Trudy)
	Carol Gallagher left – to see duty s.w. officer if any probs
	No RCA
	I/a group programme → 1030 this morning
	Just started antabuse today → Dawn
	– no bloods, ECG done (RAH last Tues)
	Will take here until Fri, then pick from RCA, supervised by Mgt
	r/w 3/12
	[signature] ST3

CLINICAL NOTES

DATE	
23/4/08	APC -
	- Nursery: Tues/Fri all day
7, 5, 2yrs - boys	1-4.
	- Doing OK.
	- Social work support with children: 2 eldest sons
	- Family matters: Maureen
	Prior to new year - off 7 mo' -
	NY: 7 days off since.
	- Still thinks about sister
	- miss her a lot - stayed a few closes up.
	- Sleeps 2am - 7am -
	- Eat at night, not during day: 5 months
	lost a wee bit of weight
	- ↓ conc°
	- Unable to enjoy things
	Meeting tomorrow with social worker/schools
	RCA - talk to Margaret.
	No problems c̄ benefits
	Imp: low mood
	Generalised suicidal ideation
	Bereavement
	Has several supports
	(P) Check bloods
	r/v 6/52
	Liaise c̄ GP re antidepressant tx
	[signature]
	Glendow ST3
	WRO

STY0411D

CLINICAL NOTES

Name: Agnes McLaughlan

Ward:

DATE	
28/5/08	APC SHO Still low. Poor sleep, appetite GP recently ↑ citalopram to 40mg nocte. Taking entabuse + vitamins RCA - Margaret. Due to start counselling soon Still many thoughts of sister who died Getting parenting support re children. SW involved Meds from GP: vitamin B Co Strong TD thiamine 100mg TD Disulpiram 200mg x2 nocte wkly 200mg x3 once wkly Diclofenac 50mg B.D citalopram 40mg nocte → advised to take in morning Appears quite flat D lmp: Still low Antidepressants recently ↑ by GP: open to change if no improvement: R/V 6/52. SHO Aberdeen Wards
27/8/8	- Phonecall received from RCA - Requesting urgent appt due to child protection issues. - Appt given for 3/9/08 to see P. Curran at APC P.C

CLINICAL NOTES

DATE	
3/9/18	DNA appt. Contacted Gina Dooley, RCA She will inform Social Work Dept. Awaiting contact from RCA as regards No circumstances. PC
10/9/18	Attended today. Alcohol free. ECG arranged Bloods taken. To attend x3 weekly. Group programme Liaise with SW Dept. PC
12/10/18	Review clinic Remains sober on antabus mood low SW may take children away. partner verbally & physically abusive Considering womens aid NO suicidal ideas P/I ↑ Citalopram 60mg R.V. 6/52 Lesley

STY0411D

CAREPLAN (ASSESSMENT) for Name..... Agnes McHugh .....

D.O.B. ..... 9/11/70 . KEYWORKER..... TM .....

DATE	NO.	PRESENTING ISSUES	GOALS	INTERVENTIONS	SIGNATURE		REVIEW DATE
					KEY WORKER	CLIENT	
		Experiencing Problems	**Record an accurate and**	**Utilise Single Shared**			
10/9/8	(1)	**related to Alcohol and other drugs.** **eg. problems related to** **Intoxification** **Regular Heavy Use** **Dependence**	**complete history / assessment**	**Assessment tool.** **Complete Risk Assessment**	PC	AM	30/10/8 .
		Detoxification may be required	**Safely complete detoxification**	**Provide information on detoxification and medication used eg chlordiazepoxide regime and vitamin supplement.** **Utilise withdrawal assessment tools as required eg. CIWA, Bp charts.**			
			Client modifies his/her behaviour	**Discuss the abstinence policy and the need for daily attendance which allows for observation of effects and monitoring of medication.** **Inform client that they must not drive whilst on medication. Provide information on DVLA requirements.** **Explore problems experienced through alcohol and allow time to discuss any difficulties.** **Provide arranged sessions to explore reasons for changing**			

				behavior. Urine Drug Screen to labs if assessed for in-patient care. Empower client to mutually agree to careplan and goals. Liase with referrer / referring agency.			
		If identified, then tick and specify... Physical Health Issues.....	Address any issues	Provide information about the effects alcohol has on physical well-being Assess nutritional state, use tool, provide information on diet and nutrition and refer to dietician as appropriate Refer to specialist services eg. skin clinic, diabetic clinic				
		Mental Health Issues.....	Address any issues	Utilise tools eg. Mini Mental Exam, Depression Inventories. Refer to Psychiatrist and/or CMHT				
		Child Care Issues.....	Alleviate concerns, ensure Children's safety, provide support to client	Gather info. on kids & those responsible for their care. Assess support needs & activate appropriate referrals	RE X_A.M		30/10/8	

Printer Friendly

Current Patient

Patient Name	AGNES M MCLAUGHLAN
CHI	0911703241
Date of Birth (dd/mm/yyyy)	09/11/1970
Reg. GP	HODGSON, COLIN
GP Practice	Incle Street Surgery
Consultant	
Ward/Location	

Current Report

Report Requestor	WILSON, HELEN
Requestor Location	Incle Street Surgery
Report Identifier	BC169190N
Dept.	BIOCHEMISTRY
Sample Type	BLOOD
Sample Collected	01/09/2008 12:07:00
Sample Received	01/09/2008 15:18:00
Processed Into Store	01/09/2008 16:07:49

Quick Links

All Results

Related Tests on this Sample

Routine Biochemistry

Add New Note

Audit

Routine Biochemistry

Description	Value	Range	Unit	Normalcy Notes
Sodium	144	135 - 145	mmol/l	
Potassium	4.5	3.5 - 5.0	mmol/l	
Chloride	**108**	**97 - 107**	**mmol/l**	**R**
Bicarbonate	26	23 - 30	mmol/l	
Urea	6.1	2.5 - 7.5	mmol/l	
Creatinine	**52**	**62 - 124**	**umol/l**	**R**
Estimated GFR (/1.73m^2)	**>60**	**90 - 140**	**ml/min**	**M**
Total Protein	77	62 - 82	g/l	
Albumin	49	37 - 50	g/l	
Alk Phos	80	33 - 117	u/l	
Bilirubin	7	0.5 - 19	umol/l	
ALT	19	11 - 55	u/l	
Gamma GT	33	8 - 60	u/l	
Globulins	28	15 - 35	g/L	

To Print: please use the 'Printer Friendly' link, or print this page in Landscape

3

SW Dept. Andrew Nolan, Kelvin Hae Tel 8424077

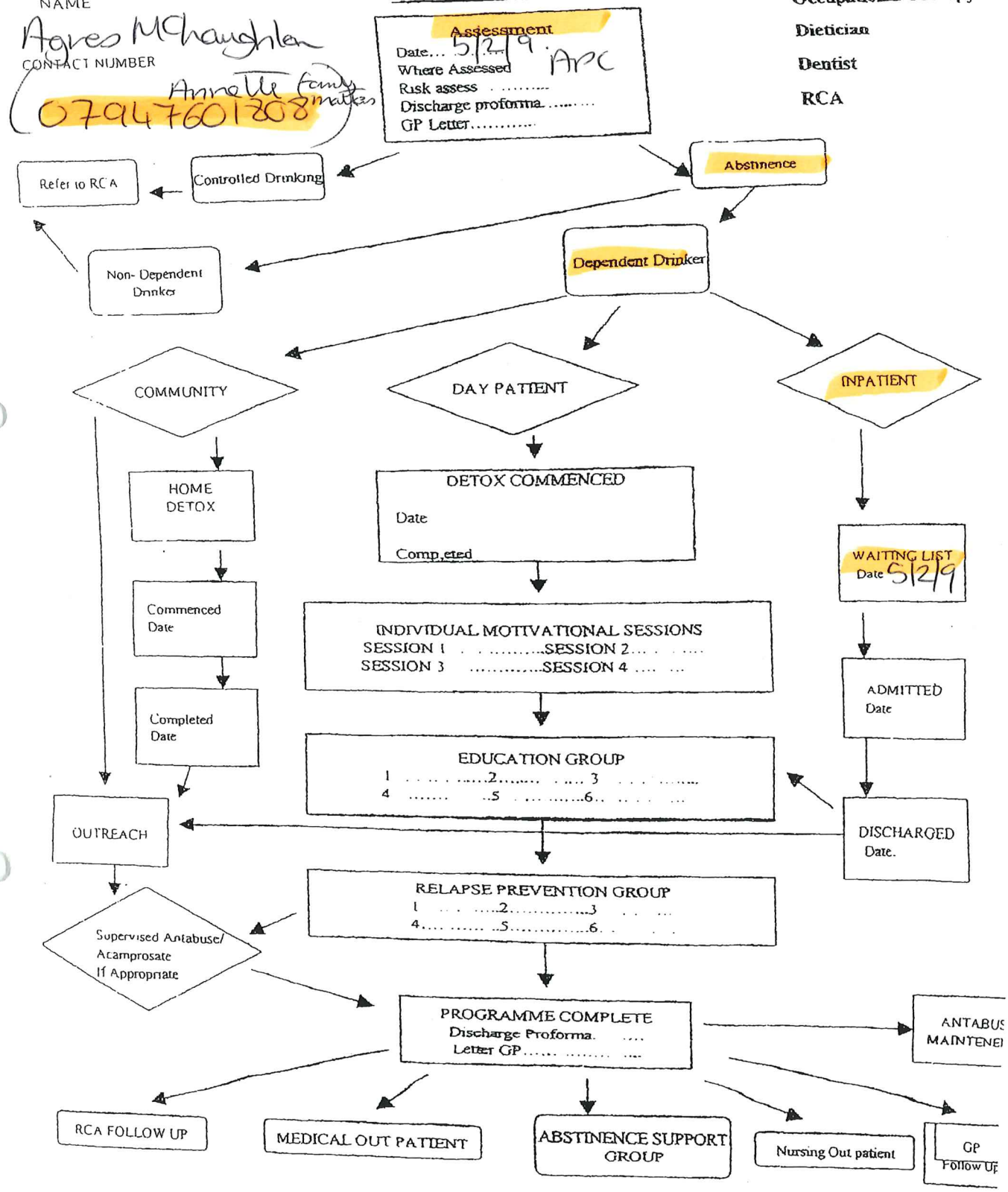
FRT 12/2/9.

Mobile 07504674233

N.H.S.GREATER GLASGOW & CLYDE
ALCOHOL PROBLEMS CLINIC
Care Pathway

NAME
Agnes McLaughlan
CONTACT NUMBER
07947601808 Annette family matters

OTHER SERVICES
Physiotherapy
Social Work
Occupational Therapy
Dietician
Dentist
RCA



Renfrewshire Joint Care Partnership

NHS Greater Glasgow and Clyde
1948-2008 60 years of the NHS

Shared Information

Client Details

Surname:	MChaughlan	**Date of Birth:**	9/11/70
Forename:	Agnes	**Social Work ID:**	
Contact Agency:	RPC	**Department:**	

I Mr/Mrs/Ms ---------- A MChaughlan ----------have had the principles of joint care planning explained to me by my health/social worker.

---------- RPC ----------. I understand that it may be necessary for information relating to me to be shared between the various agencies involved in my care, i.e.. health and social work professionals and voluntary agency staff. Where appropriate. The information shared will only be that relevant to my care and those I care for and it will be only on a "need to know " basis unless there is a risk to myself or others.

I give my consent to the sharing of my personal information for the joint care planning purposes explained to me.

I give restricted consent to the sharing of my personal information for the joint care planning purposes explained to me.

I do not give my consent to the sharing of my personal information for the purposes explained to me and I understand that this could place restrictions on the integrated service within my care plan. These restrictions have been explained to me.

I * have/have not received a copy of an information leaflet which explains how information about me is used.

Please delete as appropriate

Signed ---------- Agnes MChaughlan ---------- Date ---------- 10/9/8 ----------

Status if not client: _____

Health/Social Worker Statement:

I confirm that I have explained to ---------- A MChaughlan ---------- the principles of joint care planning, including the fact that information may be shared with others on a "need to know" basis. I have also explained that should information sharing consent be refused the level of integrated service could be restricted.

Signed ---------- P. C ---------- Date ---------- 10/9/8 ----------

Designation ---------- Snr Nurse ----------

Carenap Basic Information Sheet

Person's full name :
Mr / Mrs / Miss / Ms / Other Agnes McLaughlin
Preferred name :
DOB : 9 / 11 / 70.
Lives alone – Yes / No (please circle)

CHI number : 3241
Social work number :
Other number *(specify)* :
Gender : M / F
Ethnic Background : British/White

Referrer
Name of Referrer : RCA
Address : Murray Hse

Profession
Telephone :

Is person aware that referral has been made? Yes / No (please circle)

Reason for assessment
Assistance to stop drinking

Date of referral : 23 / 08 / 08

Person lives in? *(tick box)*

Rented – Local Authority	☐	Sheltered Housing	☐	Residential Home – Local Authority	☐
Rented – Housing Assoc.	☑	Supported accommodation	☐	Residential Home – Private	☐
Rented – Private Landlord	☐	Hospital	☐	Residential Home – Voluntary	☐
Rented – Other (specify what)	☐	Nursing Home	☐	Hostel	☐
Privately Owned	☐	Care Home	☐	Homeless	☐
Relatives home (specify who)	☐	Other (specify what)	☐		

Present address :
Post town :
Post code :
Telephone :

Home address *(if different)* :
Tel (Mobile)
Post town : 07504674288.
Post code :
Telephone :

Contact Details	**Main carer**	**Next of Kin (if different)**	**Keyholder (if different)**
Name (include title) :	Andrew Nebon.		
Relationship to person :			
Keyholder :	**Yes / No** *(circle)*	**Yes / No** *(circle)*	
Address :	Social Work Dept. Kelvin Hse.		
Post town :			
Post code :			
Tel (Day) :	842 5151		
Tel (Night) :			
Tel (Mobile) :			

Who is the GP? Dr. McMillan. Address: Anchor Mill Post town : Post code : MC. Tel (Day) : Tel (Night) : Practice number :	**Communication Needs** Preferred language : Is an interpreter required? Yes / No *(circle)* Language required ? Yes / No *(circle)* Hearing aid used? Yes / No *(circle)* Spectacles used? Yes / No *(circle)* Other - please speciify

Relevant Background History

To include where appropriate : *Work/employment, Family, Marital Status, Religion, Any other factors – Housing/Accommodation issues, recent change in abilities/function, Concerns, Risks, Social network, Bereavement,*

Relevant Medical History (including current medical conditions and medication)

UPDATE

To be used if full Single Shared assessment has been completed within the last 2 years

Drug / Alcohol Support Needs Assessment Package

Person's Name: Agnes McNaughton

Person's DOB: 9/11/70

Lead Assessor's Name: Patricia Cu

Agency of Lead Assessor: APC

Date of Assessment: 5/2/9

Date of Review:

Date of Review:

Date of Review:

Date of Review:

AGNES MCLAUGHLAN
36 MCKERRELL STREET
PAISLEY

PA1 1NN

Section 1: Basic I

Person's Full Name:

Assessor's Name: Patricia Cam

Agency: ARK

Contact Details /Tel: 314106

Location (where seen): ARK | Dykebar

PIMS Number:

T Number/Care first: Reference Number:

Consent Form Completed: YES ☑ NO ☐

Date of Assessment: 5/2/19

Date of Birth: 9/11/70

Section 2: ALCOHOL / DRUG CURRENT USE & Use since last assessment

Drugs / Alcohol History: short history since last assessment leading to present use (present use should be more detailed). Indicate type of substance (legal (L), illegal (I) or prescribed (P) Method of use

Age	Substance Used	Type (L, I or P)	Consequences
38yrs	Relapsed and using 6 cans of lager + 1½ bottle of wine	(L)	low mood - Stopped Antabuse 1wk ago [redacted]

Have you ever injected?	YES	(NO)
Have you ever shared injecting equipment?	YES	(NO)

Comments - relating to above

Section 3: SERVICE HISTORY DETAILS

Confirm that service history you have on file is accurate (Yes) NO

If No please record below relevant history

[redacted]

partner living in other house

Section 4: GENERAL INFORMATION / PROFILE

If information changed from last assessment please indicate

HOUSING (Tenancy, Problems, Complaints, Arrears, length of Tenure)
changed since last assessment: Yes (NO)
FINANCE (Present Income, Outgoings and Debts)
changed since last assessment: Yes (NO)
Income Maximization required? Yes No N/A
Employment Past/current difficulties, literacy and numeracy
changed since last assessment: Yes (NO)

EDUCATION (Past / Current Difficulties, Literacy and Numeracy)

changed since last assessment: Yes NO

CURRENT LEGAL STATUS

Please indicate status below.

☑ None	☐ Probation	☐ Licence	☐ DTTO
☐ DTTO assessment	☐ Community Service	☐ In Prison Other	☐

Details:

Previous Offences:
changed since last assessment: Yes NO

Current / Outstanding Offences:
changed since last assessment: Yes NO

Any other details (including any periods in prison)

Section 5: HEALTH INFORMATION / PROFILE

GP Details

Name: Dr McMillan **Telephone:** _____

Address: Andrew Mill Mc **Fax:** _____

_____ **E-mail:** _____

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

changed since last assessment: Yes NO

Psychological Health (including hospital admissions and current prescribed medication)

changed since last assessment: Yes NO

Section 6: SOCIAL SITUATION / CONTEXT

Brief summary of service user lifestyle and social context, relationships – this should set the scene for moving on to childcare area. Include partner name and address and whether or not partner is a drug/alcohol user.

changed since last assessment Yes NO

[redacted]

Sister unwell in RAH.

Section 8: ASSESSMENT OUTCOME / PLAN OF CARE

Identified Need *(Should be in order of priority of user)*	**Proposed Interventions** *(Demonstrate how intervention will take account of gender, ethnicity and disability)*	**Timescale** *(Include person responsible)*
Needs detox	Detox in Crythe Follow up at ARC	1-2wks

Unmet Need	**Reasons**

Client's Perception of the Above
Wants to stop

Please identify any factors related to children's issues arising from assessment

Section 8: ASSESSMENT OUTCOME / PLAN OF CARE *(continued)*

FURTHER ASSESSMENT INDICATED

Please check relevant boxes and give details of service / agency.

Alcohol Detoxification:	Inpatient	☑	Residential Rehabilitation	☐
	Outpatient	☐	Other	☐
	Home Detox	☐		
	Residential Detox	☐		

Agency / Service Details

SUMMARY OF ASSESSMENT

- Detox at Blythe Unit
- Follow up at APC
- work up for Antabuse if suitable.

NO FURTHER ACTION

Please give details why.

Service User's Signature: **Date:**

Assessor's Signature: P. Carr **Date:** 5/2/19.

Mental Health & Learning Disabilities

RISK ASSESSMENT AND MANAGEMENT (LEVEL 1)

CLIENT NAME: Agnes McGrath **D.O.B.:** 9 / 11 / 70 **ID No:**.....

ADDRESS: 36 McKenzie St, Paisley..... **POSTCODE:**.....

DATE/PERIOD OF ASSESSMENT: 5 / 2 / 9 **TIME:** 4pm **REVIEW DATE:** / /

RISK FROM OTHERS (eg. Abuse, exploitation) — YES / NO — UNKNOWN
Details of identified risk: Further investigation required*
Can be abusive when drinks

RISK TO SELF (eg. Suicide, self harm) — YES / NO — UNKNOWN
Details of identified risk: Further investigation required*

RISK TO OTHERS (eg. Aggression, violence) — YES / NO — UNKNOWN
Details of identified risk: Further investigation required*
Can be abusive when drinks. Volatile relationship

RISK OF NEGLECT (eg. Health, personal) — YES / NO — UNKNOWN
Details of identified risk: Further investigation required*
when drinks

RISK TO CHILD(REN) (eg. Neglect, abuse) — YES / NO — UNKNOWN
[redacted] Further investigation required*

RISK OF PHYSICAL IMPAIRMENT (eg. Medical, sensory) — YES / NO — UNKNOWN
Details of identified risk: Further investigation required*
with cautions drinks

RISK OF WANDERING and/or FALLS — YES / NO — UNKNOWN
Details of identified risk: Further investigation required*
When drinks

MEMORY & COGNITIVE IMPAIRMENT — YES/NO — UNKNOWN
(eg. Forgetfulness) Further investigation required*
Details of identified risk: with cautious drinks

CHALLENGES TO SERVICES — YES / NO — UNKNOWN
(eg. Inappropriate demands, poor service response) Further investigation required*
Details of identified risk:

SIGNIFICANT KNOWN HISTORY (including known diagnoses):

long history of abuse during. Using 6 cans of lager + 9 1/2 bottle table wine. Suffers shakes + sweats on with drawal.

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

Risks associated with withdrawal

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

Detox AMU/Acute Unit
Follow up at ARC

SOURCES OF INFORMATION : AVAILABLE

client

CONTEXT OF CLIENT FOR ASSESSMENT

ROLE OF CLIENT and/or CARER IN PLAN:

CLIENT INVOLVED: (YES) / NO CARER INVOLVED: YES / (NO)

CLIENT AGREED: (YES) / NO CARER AGREED: YES / (NO)

COMMENTS:

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

Recorded by: Patricia Ann Date: 5/2/19

Discussed with: Time: 4pm

PHYSICAL EXAMINATION

09/11/70

DATE	SURNAME	FIRST NAMES	AGE	UNIT No.
	Mclaughlin	Agnes		

13/2/09

GENERAL EXAMINATION HEIGHT WEIGHT

pale, ict

Gd cond; normal

CARDIO-VASC SYSTEM

PULSE 90/hrs

B.P. 120/70

HS: I+II no (M)

RESPIRATORY SYSTEM trachea c

air clear

AE=

no added sound

ALIMENTARY SYSTEM Soft

no tenderness

BS+

no organomegaly

GENITO-URINARY SYSTEM

NERVOUS SYSTEM alert, conscious

CRANIAL NERVES Vision V, hearing V, No facial asymmetry

FUNDI

REFLEXES	BI.	TRI.	SUP.	ABD.	KNEE	ANKLE	PLANTAR
RIGHT	+	+			+		
LEFT	+	+			+		

MOTOR
- Abnormal movements: None
- Power: 5/5 throughout
- Tone: Normal

SENSATIONS
- Light Touch
- Pinprick
- Vibration: ~~decreased~~ Grossly intact
- Proprioception: intact

GAIT Normal.

SUMMARY Impression: Dengue day 3

Doctor's Signature:

CLINICAL NOTES

Name

Ward

DATE	
	Agnes McLaughlin
12/2/09	09/11/70
	Alc/Hx: 1L cider + 6 cans beer daily for 6 weeks, denies any drugs. Been on antabuse + abstinent before this, for 6 months.
	3 sons taken into care by social services
	P/Med: No serious MH. Alcohol hallucinosis tx
	Soc/Hx: lives alone.
	MSE: tremulous, mood euthymic. No affective or any psychotic features. Cognition grossly intact.
	Plan ① detox day 3 ② Physical + bloods ③ ? for Sunday to detox