

RENFREWSHIRE DRUG SERVICE CLOSING SUMMARY CHECK LIST

NAME	W2SV27 PHILLIPS	CHI	0502823496	SWIFT	10072527
ADDRESS:					

ACTIONS	DATE	CONTACT NAME	METHOD EMAIL/LETTER/ R/PHONE	COMMENTS
MEDICAL APPROVAL SOUGHT FOR CLOSURE	12/4/16	closure agreed with De navigation		
CLOSING SUMMARY COMPLETED	14/4/16			
SMR 25 B COMPLETED	14/4/16			
END STAR COMPLETED	14/4/16			
WAITING TIMES UPDATED	14/4/16			
GP LETTER COMPLETED	14/4/16			
NOTIFICATIONS	DATE	CONTACT NAME	METHOD EMAIL/LETTER/ PHONE	COMMENTS
CHILD CARE CHECKLIST				
SOCIAL WORK	No CHILDREN			
HEALTH VISITING				
SCHOOL				
(OTHER)				
(OTHER)				
ADULT CHECKLIST				
MENTAL HEALTH TEAM		~1A 		
SOCIAL WORK (A.S.P)				
VOLUNTARY SECTOR				
(OTHER)				
(OTHER)				

KEY WORKER SIGN OFF:	DATE: 14/4/16
C.M. GROUP SIGN OFF:	DATE: 28/4/16

LIASON SHEET

OTHER AGENCIES INVOLVED: (Names and Contact Info)

CLIENTS NAME... Wesley P. H. B... DOB... 5/2/82
 KEYWORKER... JANIZ. KEIPER DATE... 8/10/15

CONTACT	NAME	ADDRESS	TEL NO
Prescribing Doctor	MCMAHON	RDS	618 2585
Chemist	LLYDD	ABILSTON RD	~~887~~ ~~7400~~ 884 2216
General Practitioner	Dr HOUNSTON	BARNY PRACTICE NORTHCREFT	889 3732
Social Worker			
Other Agencies Involved in Care			
N.o.K.		Glasgow?	

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

Service Users Name: WESLEY PHILIPS	CHI N°/DoB: CHI: 3196 D.O.B. 5/2/82	PIMS N°:
Legal Status: Informal ☒ Detained ☐ Community Order ☐	Ward /Dept / CMHT: RDS	

Context of Assessment

On admission ☐	Engagement with Crisis Services ☐	MDT/C.P.A. review ☐
Annual review: ☐ Significant change in presentation/circumstances ☐ Other ☐ specify		

Sources of Information

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

Guidance

This screening form should be completed as fully as possible. It is a clinical judgement when this should take place however as a general guide this may be on admission to hospital or at the point of engagement with secondary mental health services. Thereafter it should be reviewed on a regular basis as pre-determined by the clinical team or as significant changes in circumstances or clinical presentation dictate. It is expected that reviews would routinely take place at multidisciplinary meetings, the point of transition from one aspect of service to another, as part of a planned annual review, at the point of CPA review, at the point of engagement with Crisis Services. In relation to admissions to hospital, the initial screening and formulation of risk should be reviewed at the next multi-disciplinary team meeting.

- Dependant on the information collected consideration should be given to carrying out a more detailed, specific risk assessment e.g. suicide risk assessment.
- This document should form an integral part of a comprehensive mental health assessment and care planning process, and the factors listed are not necessarily in any ranked order.
- This does not attempt to be an exhaustive list of safety issues or risk factors, merely an initial guide informing clinical management.
- The expectation that all safety risks can be predicted is unrealistic, and initial assessment may be based on incomplete information.
- If completed by one person (e.g. out of hours), this assessment should be discussed as soon as is practicable with the Consultant and multi-disciplinary team (including users and carers where appropriate).
- The assessment should include the service user and carer perspective of risk.
- The assessment must take account of parenting responsibilities and contact with children.
- Please refer to the Clinical Risk Screening & Management Policy for guidance.

Screening completed by

Print Name: JACKIE WATKINS	Signature:
Designation: CAN	Date & Time: 8/10/15 2.54pm

Mental Health Partnership
Clinical Risk Screening and Management Tool

Suicide &/or Self Harm		Violence		Other Risk Factors	
History and Situational Factors					
S1	Mental illness diagnosed or diagnosis uncertain	V1	Previous violent acts	O1	Vulnerable due to learning disability, cognitive impairment or mental illness
S2	Use of violent methods	V2	Use of weapons	O2	History of stalking others
S3	Previous self-harm	V3	Previous admission to secure units	O3	History of social, financial or sexual exploitation of others
S4	Socially isolated	V4	Convictions for violence assault	O4	History of falls
S5	Past diagnosis of personality disorder,	V5	Past diagnosis personality	O5	History of self-neglect,
S6	Major physical illness	V6	Alcohol or drug misuse	O6	Lacks basic housing amenities
S7	Alcohol/drug misuse	V7	Male under 35	O7	Previous fire setting
S8	Family history of suicide	V8	Prior supervision failure	O8	Socially or culturally isolated
S9	Previous treatment non-compliance	V9	Previous treatment non-compliance	O9	Neglect - children or other dependents
S10	Impulsivity	V10	Impulsivity	O10	History of exploitation by others
Short Term or Precipitating Factors					
S11	Planning suicide	V11	Intoxicated	O11	Difficulty communicating needs/views/comprehension difficulties
S12	Access to lethal method	V12	Acute psychosis	O12	Confusion or disorientation
S13	Hopeless / helpless	V13	Violent fantasies	O13	Sexually disinhibited or aggressive
S14	Recent major loss	V14	Identified target	O14	Significant financial problems
S15	Recent psych hospital discharge	V15	Access to weapons	O15	Current self-neglect
S16	Current or recent treatment non-compliance	V16	Current or recent treatment Non-compliance	O16	Current neglect of children or other dependents
Protective Factors					
S17	Willing to respond to advice/carers	V17	Willing to respond to advice	O17	Willing to respond to advice/carers
S18	Has close relationship	V18	Appropriate services available	O18	Appropriate services available
S19	Religious beliefs				

Mental Health Partnership
Clinical Risk Screening and Management Tool



Suicide &/or Self Harm		Violence		Other Risk Factors	
History and Situational Factors					
S1	Mental illness diagnosed or diagnosis uncertain	☒	V1	Previous violent acts	☒
S2	Use of violent methods	☒	V2	Use of weapons	☒
S3	Previous self-harm	☒	V3	Previous admission to secure units	☒
S4	Socially isolated	☒	V4	Convictions for violence / assault	☒
S5	Past diagnosis of personality disorder,	☒	V5	Past diagnosis personality	☒
S6	Major physical illness	☐	V6	Alcohol or drug misuse	☒
S7	Alcohol /drug misuse	☒	V7	Male under 35	☒
S8	Family history of suicide	☒	V8	Prior supervision failure	☒
S9	Previous treatment non-compliance	☒	V9	Previous treatment non-compliance	☒
S10	Impulsivity	☒	V10	Impulsivity	☒
Short Term or Precipitating Factors					
S11	Planning suicide	☐	V11	Intoxicated	☒
S12	Access to lethal method	☐	V12	Acute psychosis	☐
S13	Hopeless / helpless	☐	V13	Violent fantasies	☐
S14	Recent major loss	☐	V14	Identified target	☐
S15	Recent psych hospital discharge	☒	V15	Access to weapons	☐
S16	Current or recent treatment non-compliance	☒	V16	Current or recent treatment Non-compliance	☒
Protective Factors					
S17	Willing to respond to advice/carers	☒	V17	Willing to respond to advice	☒
S18	Has close relationship	☐	V18	Appropriate services available	☒
S19	Religious beliefs	☐			

Mental Health Partnership
Clinical Risk Screening and Management Tool



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

Management plan	Action
Suicide/Self Harm Diagnosis of emotionally unstable personality disorder, opiate dependence (IV heroin use), benzodiazepine misuse. Extensive history of self-harm, cutting to arms and throat. History of suicidal ideation-thoughts of jumping off bridge, hanging self; previous overdose. Several short admissions to inpatient psychiatry. Recent admission to Dykebar Hospital, command hallucinations and suicidal ideation, discharged as found to be using IV heroin in ward. There appears to be a pattern whereby Mr Philips expresses suicidal ideation when he believes services are unable to respond to his demands. For example following recent discharge was recently at A & E as a needle snapped off in his groin, when he was told they were not going to remove it and not going to admit him he then stated he was suicidal and lay down in road outside hospital and was returned to A&E by police. Again today at assessment initially stated he was suicidal however when he was informed that treatment would be commencing today, he contracted to safety. <i>methadone</i> Continues to report auditory hallucinations, however no evidence of psychotic symptoms at interview. Medical notes not available for details of recent admission to Dykebar. Mr Philips has a history of poor engagement with both mental health and addiction services and poor concordance with prescriptive care in the past. PLAN Medical notes ordered. Mr Philips has been provided with contact details for RDS CAN and duty worker as well as the out of hours crisis support services which he has agreed to use if required CAN will work with Mr Philips to develop a crisis support management plan and alternative coping strategies, psychosocial interventions. CAN will encourage Mr Phillips to maintain his appointments with services and will offer him education and support in both his addiction and mental health recovery. CAN and Psychiatrist to monitor addiction and mental health referring on to mental health services as appropriate. Mr Philips to attend community Pharmacy daily for methadone. RDS to liaise with pharmacy re attendance/presentation. Philips to attend 0940 12/10/15 for review with Dr O'Neil; to be assessed for anti-psychotic medication	
Violence Forensic history, charges of carrying offensive weapons, BOP and resisting arrest, robberies involving weapons. Previous report of hostility and aggression towards staff. Again this aggression seems to be in response to Mr Philips perception that services are not going to provide what he is demanding e.g at emergency out of hours assessment 38/12/2012 became hostile and aggressive when he felt that he was not going to get admitted. Plan First home visit to be carried out by two members of staff as per lone working policy. Contact to be terminated if feeling at risk or threatened. Staff to be aware that Mr Philips can become aggressive if he perceives services not to be responding to his needs. If any aggression/threats further management plan to be discussed with MDT.	

Other Risk Factors

Has fell out with family so is socially isolated at present
Poor self care at present.

PLAN

(support worker) to engage with Mr Philips to assist with obtaining structure to day and improving self-care.

Allocation of Responsibilities

CAN Jackie Leiper, Renfrewshire Drug Service 0141 618 2585

Consultant Psychiatrist Dr McMahon RDS 0141 618 2585

GP- Dr Johnstone Barony Practice Northcroft 889 3732

Outcome of screening/management plan discussed with

Service User ☒ x

Carer ☐

Consultant ☐

Other Dr.x ☐

CPN ☐

Ward Nurse ☐

Social Work ☐

Occupational Therapy ☐

Psychology ☐

Pharmacy ☐

xOther x ☐ specify NTL Janice Bennet

Management Plan completed by

Print Name:

Jackie Leiper

Signature:

Designation:

CAN

Date & Time:

8/10/2015

For Filing

Jackie
10127958

This form should be used only to assist you in keying information directly onto the Scottish Drug Misuse Database. It **MUST NOT** be mailed to ISD. Such action constitutes a breach of the Data Protection Act 1998.

SMR25b FOLLOW-UP REPORT Introduced April 2008

1) PERSONAL DETAILS

First Name WESLEY Surname PHILIPS
 Date of Birth 5/12/1982
 Local Ref Gender Male ☐ Female ☐ City/Town PAISLEY
 CHI Number 3496 Postcode PA2 6RN

2) CO-OCCURRING HEALTH ISSUES (AT THIS REVIEW)

Tick all that apply
 Drug related physical health ☐ Mental health ☐ Alcohol ☐ Other (specify)

3) CURRENT CONTACT WITH THIS SERVICE / REFERRAL TO OTHER SERVICES

Institution code
 Contact name Jackie Leup
 Date of client review (if no review has been completed, date last seen) 21/11/16
 Is client being actively treated/cared for by this agency? Yes ☒ No ☐
 If no, please provide reason (tick all that apply)
 Received required support ☐
 Unplanned discharge ☐
 Disciplinary discharge ☐
 In prison ☐
 Deceased ☐
 Currently on agency waiting list ☐
 Other (specify) Date of Discharge

Has client been referred to another drug treatment or rehabilitation service? Yes ☐ No ☐
 If yes, please provide details Name Institution Code Date of referral
 Name Institution Code Date of referral

Has client been referred to a moving on/reintegration service? Yes ☐ No ☐
 If yes, please provide details Employability of similar ☐
 Education/training ☐
 Housing ☐
 Social Work ☐
 Other (specify)

4) PRESCRIPTION DRUGS PROFILE - Give details of current prescription related to treatment of addiction

Is the client currently on prescription? Yes ☐ No ☒ Not known ☐
 Details verified? Yes ☒ No ☐

	Drug name	Daily dosage (mg)
Main drug		
Drug 2		
Drug 3		
Drug 4		
Drug 5		

5) ILLICIT DRUGS PROFILE (PAST MONTH) - Including solvents & OTC medicine taken inappropriately

Used in past month? Yes ☐ show details No ☐ go to section 6

	Drug name	Route(s) e.g. IV/ IM/ smoke/ swallow/ inhale/ snort How often i.e. daily/ most days/ weekends/ weekly/ fortnightly/ monthly				In a 'typical' drug using day	
		Main route	How often	Other route	How often	Quantity e.g. mg/ ml/oz/binge	Spend £
Main Drug							
Drug 2							
Drug 3							
Drug 4							
Drug 5							

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6) INJECTING/ SHARING DETAILS

IN THE PAST MONTH

	Yes	No
Injected	☐	☒
Always used new equipment first	☐	☐
Used a needle or syringe that someone else has used	☐	☐
Lent someone else a needle or syringe which client has used	☐	☐
Used the same spoon, filter or water as someone else	☐	☐

7) BLOOD BORNE VIRUSES

Ever tested for:

	Yes	No
Hepatitis B	☒	☐
Hepatitis C	☒	☐
HIV	☒	☐

Date of last test

m	m	y	y
01	11	20	16
01	11	20	16
01	11	20	16

	Yes	No
Has client been at risk since last test?	☐	☒
Has client completed a course of vaccination for Hep B?	☒	☐

8) ALCOHOL PROFILE (PAST MONTH)

Consumed alcohol? Yes ☐ show details No ☒ go to section 9

How often did client have an alcoholic drink?

Every day	☐	5 - 6 days per week	☐
3 - 4 days per week	☐	1 - 2 days per week	☐
2 - 3 days per month	☐	about one day a month	☐

In a typical day how many units did the client usually have?

units

9) SOCIAL PROFILE (CURRENT)

ACCOMMODATION

Owned/ Rented	☐
Supported accommodation (drug related)	☐
Residential rehabilitation	☐
In prison	☐
Homeless - Temporary/ Unstable accommodation/ Hostel	☒
Homeless - Roofless	☐
Other (specify) _____	

LEGAL SITUATION

Tick all that apply

None	☒
Case pending	☐
DTTO	☐
On probation/ subject to supervision order	☐
In Prison	☐
Other (specify) _____	

LIVING SITUATION

Tick all that apply

With spouse/ partner	☐	Yes	☐
With parents	☐	No	☐
Alone	☒	Did not wish to answer	☐
Other (specify) _____			

HAS CLIENT BEEN IN PRISON IN PREVIOUS 12 MONTHS?

Yes	☐	No	☒	Did not wish to answer	☐
How long since release	9 MONTHS				
Name of Prison of release	HM Prison Glasgow				

EMPLOYMENT/ EDUCATION

Employed (paid or unpaid)	☐	School	☐
Support into employment	☐	Excluded from school	☐
Unemployed	☒	Full time education/ training	☐
Never employed	☐	In Prison	☐
Long term sick/ disabled	☐	Other (specify) _____	

DRUG USE FUNDED BY

Tick all that apply

Employment	☐	Benefits	☐
Crime	☐	Sex work	☐
Debt	☐	Did not wish to answer	☐
Other (specify) _____			

10) DEPENDENT CHILDREN

Does client have dependent children
If yes provide age of each child in table
Is client or their partner pregnant?

Yes	No
☐	☒
☐	☐

Please provide ages

	Child one	Child two	Child three	Child four	Child five	Child six
Living with own children						
Own children living elsewhere						
Living with partner's children						

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11) KNOWN INTERVENTIONS SINCE LAST REPORT AT THIS OR OTHER AGENCIES

FOR DRUG MISUSE

OTHER INTERVENTIONS

- Structured preparatory & motivational interventions ☐
- Residential detoxification ☐
- Community based detoxification ☐
- Specialist prescribing ☐
- GP Prescribing ☐
- Structure psychosocial intervention ☐
- Structure day programme ☐
- Residential rehabilitation ☐
- Needle Exchange ☐

- Structured alcohol intervention ☐
- Physical Health ☐
- Mental Health ☐
- Employability or similar ☐
- Education/training ☐
- Volunteering ☐
- Housing ☐
- Social work ☐

Other structured intervention (specify)

CHILDCARE INTERVENTIONS

- Nursery/Creche/After school club ☐
- Respite Care ☐
- Family support ☐

Has Local authority become involved since last report
If yes provide age of each child in table

Yes ☐ No ☐

Have any of the children had a Statutory Child Protection intervention by SWS?

Yes ☐ No ☐ Unknown ☐

Child looked after by Local authority
(Please provide ages)

	Child one	Child two	Child three	Child four	Child five	Child six
At home with parent(s)						
With kinship carer(s)						
Child looked after and accommodated						

12) LOCAL USE

1	2	3	4	5	6	7	8	9
---	---	---	---	---	---	---	---	---

Comment 8/10/15

RDS
HEALTH ASSESSMENT

NAME Wesley Philip	GP DR JOHNSTON	ASSESSOR JACKIE LEWIS OR McCallum
DOB/CHI	DATE 8/10/15 (comment)	KEYWORKER JACKIE LEWIS
KNOWN ALLERGIES/HISTORY OF ANAPHYLAXIS STATED NIL		
Urine Drug Test Record – sample sent to lab for confirmation:- YES/NO +VE opiates benzodiazepines mephedrone -VE		
Alco meter reading- Alcohol consumption - including drink of choice, how much, pattern of use STATED NIL		
History of withdrawal – including tremors, sweats, seizures, DTs Previous Alcohol Abuse ? DT's		

BP-	Height-	Weight-	MUST Score (if required)-
Pulse-	BMI-		Action taken-
Urinalysis result			
Routine Bloods TAKEN 30/9/15 WHEN IN D/B. TO BE REPEAT			
Signs of IV use- YES/NO	History of IV use- YES/NO	DVT Referral leaflet given YES/NO	
Signs of DVT- YES/NO	History of DVT- YES/NO		
Sign of Abscess/Cellulitis YES/NO	Location- GREEN	Action taken- REFERRED TO	
ECG Testing required- YES/NO	Appointment made YES/NO	DATE- 8/12/15	

TBRI DT RAN
24/10/14 ? Refused

MEDICAL HISTORY - including recent admissions, surgery, overdose, seizures, diabetes, family history etc

No FH stroke, cancer, diabetes.
 operation to @ valve for a
 heart valve, replaced off in year.
 attended A&E, stayed, consultant decided to
 leave.

	YES	NO	DETAILS
Are you currently prescribed any medication?		/	
Are you currently taking any over the counter medication?		/	
Do you see any other health professionals?		/	

BLOOD BORNE VIRUS

Have you ever been tested for:-	Yes	No	ACTION TAKEN
Hepatitis B	/		
Hepatitis C	/		states tested in 2008 -> no record.
HIV	/		
Have you put yourself at risk since your last test?	/		
Have you previously been vaccinated for Hep A & B?	/		
HEPATITS B TITRE			
IMMUNISATION STATUS			
BBV Referral Completed	(YES/NO)		referred to Hep Centre Re-tested

SEXUAL HEALTH

	YES	NO	DETAILS
Are you currently sexually active?			
What method of contraception do you use?			
Female Questions Only	YES	NO	DETAILS
Is your menstrual cycle regular? (please ask when last menstruated)			
Menopause?			
Are you pregnant?			
Pregnancy Test carried out?			
When was your last smear?			
Other info-			

NALOXONE

	YES	NO	DETAILS
HAVE YOU EVER SUFFERED / TAKEN AN OVERDOSE			
HAVE YOU EVER SEEN AN OVERDOSE			
NALOXONE INFORMATION GIVEN			
NALOXONE TRAINING DATE GIVEN			
NALOXONE SUPPLY GIVEN			
Other info-			

CHECKLIST FOR SUBOXONE

MULTIPLE ILLICIT DRUG OVERDOSE +/- ALCOHOL	
CHAOTIC POLYDRUG MISUSE WITH HIGH RISK OF OVERDOSE	
ALCOHOL DEPENDANCY	
SIGNIFICANT CARDIAC PROBLEMS	
CHRONIC CHEST / LUNG PROBLEMS	
PREVIOUS HIGH LEVELS OF METHADONE MAINTENANCE (>130)	
PREVIOUS INTOLERANCE TO METHADONE (OVERSEDATION/DROWSY)	
PREVIOUS PERSISTENT UNWANTED SIDE EFFECTS TO METHADONE	
PREVIOUS CONTINUED OPIATE MISUSE DESPITE ADEQUATE METHADONE MAINTENANCE	
HISTORY OF SEIZURES	
CURRENT ANTICONVULSANT MEDICATION (EPILEPSY / BI POLAR)	
CURRENT TREATMENT FOR HCV / HIV / AIDS / TB	

PHILLIPS, Wesley

ID:0502823490

24-OCT-2014 16:44:04

GREATER GLASGOW SITE- ROUTINE RECORD

05-FEB-1982 (32 yr)
Male Caucasian

Vent. rate	41	BPM
PR interval	146	ms
QRS duration	92	ms
QT/QTc	510/420	ms
P-R-T axes	48 43	34

*** Poor data quality, interpretation may be adversely affected
Marked sinus bradycardia

Room:

Technician:
Test ind:

Referred by:

UNCONFIRMED ECG REPORT Sys Admin 2



25mm/s 10mm/mV 150Hz 7.1.1 12SL 237 CID: 8

SID: 1569291 EID:21002 EDT: 16:14 03-NOV-2014 ORDER:

Page 1 of 1



CHI: 0502823496

Royal Alexandra Hospital

Total Att: 22

12 Mth Att: 4

Title: MR

PHILLIPS

Wesley .

DOB: 05/02/1982

Age: 33y

Sex: Male

0/1 51 THRUSHCRAIG CRES

Next of kin:

Relationship: Mother

Paisley
Renfrewshire
PA2 6PP

GP: CJ Johnstone
0141 889 3732

Attendance Date: 05/10/2015

Arrival Time: 21:29

Registration Time: 21:29

Date of Incident: 05/10/2015

Major Incident Desc:

Reason for Attendance: prv. mental health issues. needle wound on groin

Affix Label

Nursing Assessment

Alerts: Not Recorded

Allergies: None Known

Pain Score:

Triage Category: 2

Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: 05/10/2015 22:00

Nurse name: Nurse Emma Johnston

Temp		C
HR		bpm
BP	/	mmHg
MAP		mmHg
RR		bpm
SpO2		%
Oxygen		%

BM		mmol/L
PF		1/min
Expected PF		1/min
Weight		kg
Height		cm
Visual Acuity		
Left		
Right		
Corrected?		

GCS	
Eyes	
Motor	
Verbal	
Total	

Pupils: Right	Pupils: Left
Size (mm)	Size (mm)
Reaction	Reaction

Nursing Notes: in dykebar from last monday till today, auditory hallucinations, took heroin saturday and needle snapped in groin, still insitu, pain ++, dihydracodeine taken today

Child Assessment Questionnaire

	YES	NO
Previous attendance (consider any relevant trauma from previous presentations)		
History variable between accounts		
Examination not compatible with history/presentation		
Delay in presentation		
Fracture/head injury or significant bruising in baby or non-mobile toddler		

Discuss with Senior Medical Staff / Nurse on duty any factors identified

X-Ray and Other Reports to be filed on this side (if the patient is not being admitted)

**DO NOT WRITE
HERE PLEASE**

ONCE ONLY PRESCRIPTIONS (including Tetanus Prophylaxis)						
Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Time of Administration	Signature	Given By

Date	CLINICAL NOTES
	Seen by (Dr) <u>Bengale</u> Time seen <u>2257</u> 5/10/15 33y O - LVDU. HR - 109 RR - 16 Sats 96% T - 38.5 BP - 130/50. Was in Dyke bar last night → injected heroin whilst on premises → pt feels he snapped the needle & it's stuck in (R) groin → He states he was found to have injected drugs - hence discharged. → He's fought as he thinks needle will harm & cut it. checked: → ° face / chills / rigors → c/o naggy pain in (R) groin. → ° pins / needles or numbness in (R) leg <u>Syrus to oncall at Dyke bar</u> <u>Mohalla</u> → - Borderline PD. - Substance abuse - Gambling problem. - admitted for 2 wk - absconded on Sunday → brought back by friends - Seen by Dr Benny saw him today → discharged from. Dyke bar. ^{com pay} o/b <u>undisturbed</u> pin point pupils. - ? injected recently oes 15/15 PRR o/paller / icterus. Chest - good AR 6/11 on here / up L CVS 1-15 1+1+0 JVP ↔ small echo

Date	CLINICAL NOTES
	Abdo. soft - non tender gins (R) → swelling / bruising phosphate imm. Oabren. (R) leg → NV intact (P) Xray + Rlv Xray → can see FB. Explained to pt that will do more harm trying to remove the needle than leaving it alone & to attend Rlv if more problems at this point, pt states he is feeling suicidal & wants to kill himself → Pt had not stated any intent till I told him he will be charged. → see & perform

Discharge Codes (Please CIRCLE)								Discharge date	
1. Admission 2. Discharge 3. Refer to GP 4. Transfer to other (see below) 5. Died 6. Refer to OP Clinic (see below) 7. Irregular Discharge 8. D.O.A.								Discharge time	
Ward number (if admitted):			Transfer to hospital:				Consultant (if admitted):		
Follow up	Arranged			Not arranged			To be arranged		
Clinic referred to	A&E	Hand injury	Fracture	Pop Check	Medical	Surgical	ENT	Others (specify):	
Discharge Prescription Packs									
Date Given	DRUG (BLOCK CAPITALS)		Dose	Method of Administration		Frequency	Signature		Given By

Emergency Department Nursing Documentation

12



Patient



bel

Presenting Complaint: NECK IN GROW

Date and Time: 5-10-15 - 22-30

Named Nurse(s): <u>L. BROWN</u>		Initials: <u>LB</u>		Communication (Please tick when completed)		Initials: <u>LB</u>	
Patient preparation (Please tick when completed)		Initials: <u>LB</u>		Communication (Please tick when completed)		Initials: <u>LB</u>	
Prepare patient for examination	☒	Communication Aids (spectacles / hearing aid)	☐	Provide blankets if required	☒	Relatives present?	☒ <u>NO</u>
Clothing bagged, labelled and stored under trolley	☒	Relatives / NOK informed	☐	Name-band (if required) <u>NKDA</u>	☒	Interpreter required	☐
		Telephone interpretation required	☐				
Observations and Investigations (Please tick when completed)		Initials:		Observations and Investigations (Please tick when completed)		Initials:	
Vital Signs recorded on NEWS chart and NEWS score recorded. Record Pain, blood sugar and neuro obs on NEWS chart if appropriate.	☐	IV Cannula (if required) dated and timed	☐	Peak Flow 1. 2. 3.	☐	Blood samples taken	☐
12 Lead ECG	☐	Urinalysis and Specimen if indicated	☐	Cardiac Monitoring	☐	Results:	
X-rays performed	☐	HCG specimen if indicated	☐	Other: please add	☐	Weight:	☐
		+ve ☐ -ve ☐ Strip Lot no:					
Screening Tools (Please circle or tick as appropriate)		Initials: <u>LB</u>		Screening Tools (Please circle or tick as appropriate)		Initials: <u>LB</u>	
SEPSIS risk? SIRS Criteria 2 or more and suspicion of infection	<u>Y</u> <u>N</u>	Preliminary Pressure Ulcer Risk Assessment	<u>Y</u> <u>N</u>	AMT 4 (if >65 years) SCORE	<u>Y</u> <u>N</u>	The patient can reposition themselves whilst in the department?	<u>Y</u> <u>N</u>
At risk of falls? (clinical judgement) (consider alcohol, mobility, age, illness, cognitive impairment etc). If at risk complete risk assessment	<u>Y</u> <u>N</u>	There is no reported skin damaged other than presenting trauma?	<u>Y</u> <u>N</u>	Mental Health Triage Assessment	<u>Y</u> <u>N</u>	The person is fully continent?	<u>Y</u> <u>N</u>
Child Protection considered (in line with policy)	<u>Y</u> <u>N</u>	If NO to any of the above initiate Waterlow risk assessment (within 4 hrs)	<u>Y</u> <u>N</u>	Waterlow Score	☐	If >10 commence Active Care	☐
GMAWS	<u>Y</u> <u>N</u>	Active Care (clinical judgement) (include all trolley patients at risk of pressure ulcers and all trolley patients in department for >4hrs) Record on Active Care Chart	☐	Pressure damage identified on arrival in ED is documented in clinical notes	☐		
Swallow test (If CVA/stroke)	<u>Y</u> <u>N</u>	Grade 3 or 4 Pressure Ulcers are reported on DATIX	☐				
Pause for Transfer (Please tick when completed)		Tick when completed	N/A	Notes			
Relatives informed	☐	☐		Information on discussion with relatives			
Cannula dated and timed	☐	☐					
Name band	☐	☐					
AMT4	☐	☐					
NEWS chart	☐	Always					
Prescriptions signed	☐	☐					
Infusions	☐	☐					
Drugs	☐	☐					
Fluids	☐	☐					
GMAWS	☐	☐					
Belongings (including patient's medications)	☐	Always		Please note here if any other tasks required prior to transfer			
Bed requested, accepted and ward informed	☐	Always					
Notes: medical notes, GP letter, PRF	☐	Always					
Investigations	☐	☐		Print name			
CXR reviewed	☐	☐					
ECG reviewed	☐	☐					
Bloods sent	☐	☐					
Bloods reviewed	☐	☐					
Patient on O ₂ ; cylinder checked	☐	☐					
Patients requiring analgesia: sufficient	☐	☐					

Patient Addressograph Label

Pause for Discharge (Please tick when completed)	Tick when completed	N/A	Notes
Advice leaflets given	☐	☐	Information on discussion with relatives
Belongings (including patient's medications)	☐	Always	
New medications explained	☐	☐	
Cannula removed	☐	☐	
Relatives aware of discharge	☐	☐	Please note here if any other tasks required prior to discharge
Social/ Support Services required and contacted	☐	☐	
SAS transport required and ref no	☐	☐	Print name
Other means of transport arranged by nurse	☐	☐	

Nursing Notes

[illegible]

NEWS – National Early Warning Score

Name
Address



CHI No.
DoB

	Date	Ward
Admitted		
Transferred		
Transferred		

Physiological Parameter	NEWS – NHS Early Warning Score						
	3	2	1	0	1	2	3
Respiration Rate	≤8		9-11	12-20		21-24	≥25
Oxygen Saturations	≤91	92-93	94-95	≥96			
Any Supplemental Oxygen		Yes		No			
Temperature	≤35.0°		35.1-36.0°	36.1-38.0°	38.1-39°	≥39.1°	
Pulse	≤40		41-50	51-90	91-110	111-130	≥131
Systolic BP	≤90	91-100	101-110	111-219			≥220
Conscious Level				A			V, P or U

NEWS should not replace sound clinical judgement. Any concerns regarding the patient's condition should be appropriately escalated and documented in the Nursing Notes.

See NEWS Actions Reference Tool for local escalation policy

NEWS Score	Frequency of Monitoring	Clinical Response
0	Minimum 12 hourly	Continue routine NEWS monitoring with every set of observations.
Aggregate 1- 4	Minimum 4 hourly	- Inform trained nurse. - Trained Nurse assessment: - Assess the patient - Review frequency of monitoring required - Assess need for escalation of clinical care and direct as appropriate.
Aggregate 5 or more or 3 in one parameter	Increased frequency to a minimum of 1 hourly	- Trained Nurse assessment. - Inform medical team caring for the patient. - Urgent assessment by a medical / surgical / nursing team with core competencies to assess acutely ill patients. - Consider level of monitoring required in relation to clinical care.
Aggregate 7 or more	Continuous monitoring of vital signs	- Trained Nurse to assess immediately. - Inform medical team caring for the patient – this should be at least senior medical staff level. - Emergency assessment by a clinical team with core competencies in the assessment of critically ill patients. This team will have critical care competencies and a practitioner/s with advanced airway skills and resuscitation skills. - Consider referral to high dependency or ITU.

DATE 5/10/15		DATE		NEW	
TIME 2205		TIME		0	1
Resp. Rate Mark: •	35		35		
	30		30		
	25		25		
	20		20		
	16	•	16		
	12		12		
	8		8		
SpO₂ (Enter Value)	≥ 96	96	≥ 96		
	94-95		94-95		
	92-93		92-93		
	≤ 91		≤ 91		
Any Sup'l O₂	%		%		
Room air		A			
Temp. Mark: X	39°		39°		
	38.5°		38.5°		
	38°		38°		
	37.5°		37.5°		
	37°		37°		
	36.5°	X	36.5°		
	36°		36°		
	35.5°		35.5°		
35°		35°			
Pulse Mark: •	170		170		
	160		160		
	150		150		
	140		140		
	130		130		
	120		120		
	110		110		
	100	•	100		
	90		90		
	80		80		
	70		70		
	60		60		
	50		50		
	40		40		
	30		30		
Blood Pressure Mark: ◇	230		230		
	220		220		
	210		210		
	200		200		
	190		190		
	180		180		
	170		170		
	160		160		
	150		150		
	140		140		
	130		130		
	120	^	120		
	110		110		
	100		100		
	90		90		
	80		80		
70		70			
60		60			
50	✓	50			
NEWS SCORE using Systolic BP					
Conscious Level Mark: •	Alert	•	Alert		
	Verbal		Verbal		
	Pain		Pain		
	Unresp		Unresp		
Total NEWS (with all obs)			NEWS SCORE		
BM			BM		
Pain			Pain		
Nausea			Nausea		
Urine output			U/O		
Obs due			Obs due		
Initials		EF	Initials		

5 KEY

2

3

PHILLIPS
Wesley

DATE

TIME

Resp. Rate

SpO₂

Temp.

Pulse

Blood Pressure

35
30
25
20
16
12
8

≥ 96

94-95

92-93

≤ 91

%

39°

38.5°

38°

37.5°

37°

36.5°

36°

35.5°

35°

170

160

150

140

130

120

110

100

90

80

70

60

50

40

30

230

220

210

200

190

180

170

160

150

140

130

120

110

100

90

80

70

60

50

Alert

Verbal

Pain

Unresp

NEWS

SCORE

BM

Pain

Nausea

U/O

Obs due

Initials

COMA SCALE		PUPILS		LIMB MOVEMENT		
Date:						
Time:						
COMA SCALE	E Eyes open	Spontaneously	4			
		To speech	3			
		To pain	2			
		None	1			
	V Best Verbal response	Orientated	5			
		Confused	4			
		Inappropriate words	3			
		Incomprehensible sounds	2			
		None	1			
	M Best motor response	Obeys	6			
		Localises	5			
		Flexion - withdrawal	4			
		Flexion - abnormal	3			
Extension to pain		2				
None		1				
TOTAL SCORE						
PUPILS	R	Size				
		Reaction				
	L	Size				
		Reaction				
LIMB MOVEMENT	ARMS	Normal power				
		Mild weakness				
		Severe weakness				
		Spastic flexion				
		Extension				
		No response				
	LEGS	Normal power				
		Mild weakness				
		Severe weakness				
		Spastic flexion				
		Extension				
		No response				
					Eyes closed by dwelling = C Endotracheal tube or tracheostomy = T Usually record the best arm response + reacts = no reaction C: eyes closed	
					Record right (R) and left (L) separately if there is a difference between the two sides	

Pupil size (mm)

- 1
- 2
- ◐ 3
- ◑ 4
- ◒ 5
- ◓ 6
- ◔ 7
- ◕ 8

Ask the patient to rate his/her pain by choosing a number between 0 and 10. Use the diagram below to assist the patient. If patient's pain is chronic, use generic tool. If patient is unable to communicate, use observational tool.

0	1	2	3	4	5	6	7	8	9	10
No Pain	Mild Pain			Moderate Pain			Severe Pain			

0	= None
1	= Mild (Not distressing – no retching/vomiting)
2	= Moderate (Troublesome – occasional retching/vomiting)
3	= Severe (Distressing – frequent retching/vomiting)

[illegible]

Emergency Department Mental Health Assessment

This side to be completed by medical staff

Outline of current presentation and precipitating factors

Pt is starting to state he is suicidal as soon as he told him he is discharged from his prison problem.

Pt states he wants admitted & will feel secure if admitted

Wesley Phillips

050 2823496

Previous mental health problems, self harm, addictions, medication etc

Seen & assessed by Carers - P. Dr Berny - yesterday during the day today. Pt was told to attend ED this afternoon for xray

→ Borderline Personality Disorder

→ substance misuse

Other relevant information; relationships, finances, employment, housing, physical health, childcare etc

Lives alone
unemployed

Appearance

Appropriate interaction in environment
agitated

Behaviour

Thought
of self-harm

Speech

Normal tone
& content

Mood

Euthymic
- above

Thought

of self-harm

Insight

has insight
behaviour indicates anorexia

Risk Assessment

Based on clinical assessment, indicate a category of risk of a further episode of self-harm in the short term - 48 hrs - considering any protective as well as precipitating factors

High/Moderate/Low

Summary and Plan for Further Assessment

Referral to liaison psychiatry, duty doctor, CPN service, CMHT, GP, addiction services, SW, etc.

Summary

No ongoing psychosis, has

Service Referred to

borderline of BPD & carers
& long delays via crisis / CP

Time of Referral

Discharge

Indicate the follow-up plan, advice given, and identities of others informed of the decision

Follow up and advice

Carer informed

Name and Designation of Consultant
Middle-Grade Involved in Reviewing Patient

[Signature]

Burgill

Risk Factors (yes/no/unknown)

male gender	y	n	u
age >18 and <65	y	n	u
depression	y	n	u
alcohol or drug use	y	n	u
separated, widowed, divorced	y	n	u
suicide plan/concealment	y	n	u
evidence of psychosis	y	n	u
ongoing suicidal intent	y	n	u
lack of social support	y	n	u
chronic physical illness/pain	y	n	u
family history of suicide	y	n	u
family concerned about risk	y	n	u
disengaged/poor compliance	y	n	u
unemployed or retired	y	n	u
access to lethal means of harm	y	n	u
previous violent methods	y	n	u
history of self harm/overdose	y	n	u
previous psychiatric treatment	y	n	u
current psychiatric treatment	y	n	u
current use of benzodiazepines	y	n	u

If young people in foster or residential care are assessed, their social work team should be informed, (via standby SW if out-of-hours), and correspondence given to carers present.

Print Name

Burgill

Signature

[Signature]

Date & Time

13/5/10/15

Urea & Electrolytes

[View Cumulative Results](#)

Time Collected 30-Sep-2015 08:30 Time Received 30-Sep-2015 20:29
Time Reported 01-Oct-2015 08:53 Order Number B,15.7419951.S
Status Final Source System Telepath
Comments REQUESTOR**OPIATE DEPENDANT

Test	Result	Ref. Range (Units)	Abnormality
Sodium	141	133 - 146 mmol/L (mmol/L)	+
Potassium	* 6.0	3.5 - 5.3 mmol/L (mmol/L)	
Chloride	105	95 - 108 mmol/L (mmol/L)	
Urea	3.4	2.5 - 7.8 mmol/L (mmol/L)	
Creatinine	74	40 - 130 umol/L (umol/L)	
Estimated GFR	>60	>60 ml/min (ml/min)	

* Abnormal ** Not in use

Thyroid funct test

[View Cumulative Results](#)

Time Collected 30-Sep-2015 08:30 Time Received 30-Sep-2015 20:29
Time Reported 01-Oct-2015 08:53 Order Number B,15.7419951.S
Status Final Source System Telepath
Comments REQUESTOR**OPIATE DEPENDANT

Test	Result	Ref. Range (Units)	Abnormality
TSH	0.50	0.35 - 5.00 mU/L (mU/L)	
Free T4	18.2	9.0 - 21.0 pmol/L (pmol/L)	
Total T3			

* Abnormal ** Not in use

Liver Function Tests

[View Cumulative Results](#)

Time Collected 30-Sep-2015 08:30 Time Received 30-Sep-2015 20:29
Time Reported 01-Oct-2015 08:53 Order Number B,15.7419951.S
Status Final Source System Telepath
Comments Alkaline Phosphatase results IFCC aligned from 03/08/15.
REQUESTOR**OPIATE DEPENDANT

Test	Result	Ref. Range (Units)	Abnormality
Total Bilirubin	4	<20 umol/L (umol/L)	
ALT	15	<50 U/L (U/L)	
AST	23	<40 U/L (U/L)	
Alkaline Phosphatase	83	30 - 130 U/L (U/L)	
Albumin	36	35 - 50 g/L (g/L)	

* Abnormal ** Not in use

Glucose View Cumulative Results

Time Collected 30-Sep-2015 08:30 Time Received 30-Sep-2015 20:29
Time Reported 30-Sep-2015 21:03 Order Number B,15.7542711.S
Status Final Source System Telepath
Comments REQUESTOR**OPIATE DEPENDANT

Test	Result	Ref. Range (Units)	Abnormality
Glucose	4.9	3.5 - 6.0 mmol/L (mmol/L)	

* Abnormal ** Not in use

Bone Profile

[View Cumulative Results](#)

Time Collected 30-Sep-2015 08:30 Time Received 30-Sep-2015 20:29
Time Reported 01-Oct-2015 08:53 Order Number B,15.7419951.S
Status Final Source System Telepath
Comments Alkaline Phosphatase results IFCC aligned from 03/08/15.
REQUESTOR**OPIATE DEPENDANT

Test	Result	Ref. Range (Units)	Abnormality
Calcium	2.38	2.20 - 2.60 mmol/L (mmol/L)	
Calcium (adjusted)	2.43	2.20 - 2.60 mmol/L (mmol/L)	
Phosphate	1.30	0.80 - 1.50 mmol/L (mmol/L)	
Albumin	36	35 - 50 g/L (g/L)	
Alkaline Phosphatase	83	30 - 130 U/L (U/L)	

* Abnormal ** Not in use

C-reactive Protein [View Cumulative Results](#)

Time Collected	11-Feb-2015 09:07	Time Received	11-Feb-2015 11:00
Time Reported	11-Feb-2015 12:04	Order Number	B,15.7032247.Q
Status	Final	Source System	Telepath

Test	Result	Ref. Range (Units)	Abnormality
C Reactive Protein	* 22	0 - 10 mg/L (mg/L)	+

* Abnormal ** Not in use

Serum Vitamin B12 View Cumulative Results

Time Collected 30-Sep-2015 08:30 Time Received 30-Sep-2015 20:29
Time Reported 01-Oct-2015 12:23 Order Number B,15.7419951.S
Status Final Source System Telepath
Comments REQUESTOR**OPIATE DEPENDANT

Test	Result	Ref. Range (Units)	Abnormality
Serum Vitamin B12	^a NA		

* Abnormal ** Not in use

^a Insufficient

Full Blood Count

[View Cumulative Results](#)

Time Collected 30-Sep-2015 08:30 Time Received 30-Sep-2015 20:30
Time Reported 30-Sep-2015 20:43 Order Number B,15.8351136.W
Status Final Source System Telepath
Comments REQUESTOR**opiate dependent auditory hallucinatio

Test	Result	Ref. Range (Units)	Abnormality
White Blood Count	7.7	4.0 - 11.0 x10 ⁹ /l (x10 ⁹ /l)	
Red Cell Count	5.14	4.50 - 6.50 x10 ¹² /l (x10 ¹² /l)	
Haemoglobin	142	130 - 180 g/l (g/l)	
Haematocrit	0.453	0.400 - 0.540 l/l (l/l)	
Mean Cell Volume	88.1	80.0 - 100.0 fl (fl)	
MCH	27.6	27.0 - 32.0 pg (pg)	
Platelet Count	388	150 - 400 x10 ⁹ /l (x10 ⁹ /l)	
Neutrophils	3.0	2.0 - 7.5 x10 ⁹ /l (x10 ⁹ /l)	
Lymphocytes	3.5	1.5 - 4.0 x10 ⁹ /l (x10 ⁹ /l)	
Monocytes	0.5	0.2 - 0.8 x10 ⁹ /l (x10 ⁹ /l)	
Eosinophils	* 0.6	0.0 - 0.4 x10 ⁹ /l (x10 ⁹ /l)	+
Basophils	0.1	0.0 - 0.1 x10 ⁹ /l (x10 ⁹ /l)	
Nucleated RBC	0	(x10 ⁹ /l)	

* Abnormal ** Not in use

US Elbow Rt

Time Collected	09-Feb-2015 11:45	Time Received	09-Feb-2015 12:28
Time Reported	09-Feb-2015 12:26	Order Number	C418H29942360
Status	Final	Source System	MiSys

US Elbow Rt
Wesley Phillips
Clinical History :

Final

33 yr old IVDU. Injected 11 days ago. Increasing edema and erythema over last 2-3 days. ? pseudoaneurysm, ?abscess

US Elbow Rt :

Egg sized erythematous mass at the medial aspect of the antecubital fossa is typical of a superficial abscess with inflammation of the adjacent deep subcutaneous fat. Increased vascularity throughout the inflamed fat. No abnormal vascular flow within the abscess cavity. Patent antecubital veins lie both medial and lateral to this abscess. The intact brachial/antecubital artery lies lateral to this mass. No evidence of a pseudoaneurysm.

Conclusion - US appearance is of a subcutaneous abscess with extensive inflamed vascularised adjacent subcutaneous fat. No evidence of an underlying vascular complication. In particular, no evidence of a pseudoaneurysm.

Reported by: Dr Alexander MacLennan
Verified by: Dr Alexander MacLennan

Carenap Basic Information Sheet

Person's full name:

Mr / Mrs / Miss / Ms / Other

Preferred name:

Wesley Phillips

DOB:

5/2/80

Lives alone - **Yes** / **No** (please circle)

CHI number: 0502803496

Social Work number:

10072527

Other number (specify):

Gender: M / F

Ethnic Background:

Referrer

Name of Referrer:

Profession:

GP

Address:

Telephone:

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

Reason for assessment

Date of referral:

18/2/18

10 hours use

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:

FEAT 01/1
51 Thrusherley Cms.

Post code:

PA2 6PB

Telephone:

070070829296

Home address (if different):

Post town:

Post code:

Telephone:

Contact Details

Name (include title):

Relationship to person:

Keyholder:

Address:

Post town:

Post code:

Tel. (Day):

Tel. (Night):

Tel. (Mobile):

Main Carer

Yes / **No** (circle)

Next of Kin (if different)

Yes / **No** (circle)

Keyholder (if different)

Who is the GP? Dr.

Address:

Post town:

Post code:

Tel. (Day):

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)

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,

see referral letter + case notes.

A. Zou
P. Well

Relevant Medical History (including current medical conditions and medication)

Single Shared Assessment

Drug / Alcohol Support Needs Assessment Package

14th April 2008: Version 12



0502823496

**PHILLIPS
WESLEY**

05/02/1982 M

Person's Name:

Person's DOB:

Lead Assessor's Name:

Agency of Lead Assessor:

Date of Assessment:

Date of Review:

Date of Review:

Date of Review:

Jennie Harper
ROD
Completed 8/10/15

Section 1: BASIC INFORMATION

Person's Full Name:	Wesley Phillips	CHI / PIMS Number:	3496
ADDRESS	6151 Thrushway Concord MA 01742 (5725)	SWIFT/CARE FIRST/REFERENCE Number:	100-72527
GP NAME, ADDRESS AND TEL NUMBER	Dr. Johnson Brongy Bactell	Date Consent Form Completed:	
Location (where seen):	RDS	Date of Birth:	5/2/82

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
Heroin 1/10 into groin 2x10, sometimes unit on own DIABETES	I	DEPENDENCE, ABZ - NEED 12 SHUT IN GROOM BEGGING FOR MONEY TO FINANCE
diazepam 20x10mg daily	I	poor mental state

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

Comments – relating to above

STAYS PREVIOUS HZPC + - CARED WITH
TREATMENT. At Risk SINCE - REQUIRES
FURTHER TREATING

Section 2: ALCOHOL / DRUG CURRENT USE & HISTORY (contd)

History			
Age	Substance Used (What, How much, How Often)	Type (Legal, illegal or prescribed)	Consequences
8/9	cras, glue. for approx 1-2yrs.	I	Problematic behaviour
9	cannabis, alcohol	I	Problems at school & home
12	Oxycodone, ecstasy & amphetamine	I	
14	Smoked heroin - until was a dealer in Liverpool	I	
16	Used methadone. heavy drinking in heroin, daily then occasionally - use as part of poly-substance heroin, alcohol, benzodiazepines, methadone & OXICODONE	I	offending behaviour Dependent
25/26	Methadone Involuntary CDT '06-07.	L	substance misuse continued. periods in custody
29	Detained self for methadone, released from prison		Relapse - heroin, crack, valium's recommenced by East Ren. then back in prison
32	re-commenced on methadone		- Back in prison

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)		
CDT INVOLENT 2007	METHADONE	DORNGATE - CUSTODIAL SENTENCE		
CHRISTIAN REHAB ENGLAND - 2006	RESIDENTIAL REHAB	Put out after 1 week - INAPPROPRIATE BEHAVIOUR TOWARDS FEMALE & DEPRESSION		
CHRISTIAN REHAB 27/12 2009 - 3/1/11	PRESENTED - NOT ADMITTED DUE TO INTOXICATION THEN OFFENDING HISTORY.			
BIRMINGHAM				
EAST REN 2011	METHADONE	TRANSFERRED TO ROD		

MGT PARKINSON
ROD - 2011-14.

METHADONE

3

POOR ENGAGEMENT
PRISON 2014.

RELAPSE SOON AFTER
LEAVING - LEFT EARLY

MGT CHRISTIAN REHAB
2015 - 2016-1

Section 4: GENERAL INFORMATION / PROFILE									
HOUSING (Tenancy, Problems, Complaints, Arrears, Length of Tenure)					Yes		No		N/A
Details: CURRENTLY IN HOMELESS ACCOMMODATION									
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: D.A. CURRENTLY BEGGING									
Income Maximisation Required?					Yes		No		N/A
EMPLOYMENT (Past/Current Difficulties, Literacy and Numeracy)					Yes		No		N/A
Details: UNEMPLOYED									
EDUCATION (Past/Current Difficulties, Literacy and Numeracy)					Yes		No		N/A
Details: STATES NIL									
CURRENT LEGAL STATUS (Please indicate status below)					Yes		No		N/A
None		Probation			Licence		DTTO		
Community		In Prison			Other		DTTO Assessment		
Details:									
Previous Offences:					Yes		No		N/A
Carrying offensive weapon. 2x robberies B.O.P. resulting arrest									
Current / Outstanding Offences					Yes		No		N/A
At court NOV 2015.									
Any Other Details (including any periods in Prison)									
16YRS - GREENOCK PRISON - THREATENING Parents with PICK AXE - B.O.P.									
20YRS - 30 DAYS, CARRYING A KNIFE									
25YRS - JULY '07 - 2 SEPT 2008 - ROBBERY (ARMED WITH KNIFE)									
SEPT - DEC 2014									

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 _____

STATES HEP DABNOAS IN 2008 / STATES CURED WITH TREATMENT. SUBSEQUENT EXPOSURE TO RISK - REQUIRES BBV TESTING. P
STATES NO ALLERGIES.
STATES NO PHYSICAL ISSUES, NIL MEDICATION
RECENT NEEDLE BECAME OFF WHEN USING IV INTO GROIN. - X-RAYED AT A&E - TO REMAIN IN SDU. STATES STILL PAINFUL.

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

EXTENSIVE HISTORY OF SELF-HARM, CUTTING TO ARMS AND THROAT, HISTORY OF SUICIDAL IDEATION, THOUGHTS OF JUMPING OFF BRIDGE, HANGING, RECENTLY ~~THROW~~ LAY ON ROAD Hoping TO BE RUN DOWN. APPAR TO GO INTO CZ WITH NOT GETTING WHAT HE HAS ASKED FOR E.G. ADMISSION TO HOSPITAL.

SEEN BY PSYCHOLOGIST SINCE AGE 7 AND ADHD IN CHILDHOOD
DABNOSSO WITH TOURETTES AND EMOTIONALLY UNSTABLE PERSONALITY DISORDER,
ADMISSION to I/P. Stobhill 2005, RAN 2006,

2001, 2015.

Today reports voices clearly inside his head. Did not appear unduly distressed, anxious or responding to hallucinations

No current medication - s to be reviewed re commencement on antipsychotics

Section 6: SOCIAL SITUATION / CONTEXT

Living / Domestic Arrangements; Family Relationships (Past and Present); Current/history of domestic violence

Current

currently living alone in homeless flat
States family not speaking with him at present
No relationship, no ~~parent~~ ^{any} children

Past

Born in Port Glasgow ^{? Germany} he is youngest of two other brothers. Parents separated when he was 19. Described substance misuse from very young age and family members were involved in drug dealing. Early childhood through teens he described police involvement due to arguments to his parents. Mother died 2007 whilst Ashley in custody. Suspended from school then expelled aged 16.
5

Section 7: INFORMATION ON CHILDREN, PREGNANCY & OTHER CARE RESPONSIBILITIES

Children?	Yes	No	Contact with children	Yes	No
			Frequency of contact		
Name	D.O.B	Address	Main Carer	Nursery /School	SW Status
Who is the main carer?	Relationship to Adult / Child	Any Care Responsibilities to Children / Child Under 16			
Who is in the household (over the age of 16 either resident or on a regular basis)	Relationship to Adult/Child	Do they hold any care responsibilities to Children/Child Under 16 (eg school run , baby sitting etc.			
1.					
2.					
3.					

Have they had regular contact with support services (establish contact with SNIPS / New Expectations / SW Referrals to determine level of contact/care plan and summaries, discuss any prescribing issues in relation to stability during pregnancy. Potential of neo-natal withdrawal).
Has a Pre-Birth initial or full discussion been arranged? Date for Same
If no – initiate with senior a SW pre-birth process to inform support needs

Section 7: INFORMATION ON CHILDREN, PREGNANCY & OTHER CARE RESPONSIBILITIES <i>(continued)</i>				
Other care Responsibility?		Yes	No	N/A
Name	DOB	Address		Main Carer
Relatives / Other Agencies Arranging Childcare:		Yes	No	N/A
Is childcare arrangements made on a regular basis by extended family.				
Who provides this, benefits of support				
How often (This will establish planned respite for children/networks and areas of potential resilience)				

Help Required with Children or Arranging Childcare:	Yes	No		N/A	
What assistance could be provided and by whom					
Has client agreed to action suggested				Yes	No
If yes specify action					
Social Work Contact		Yes	No		
Contact with other allocated worker/s and summarise priority areas for parent and child joint care planning if no state why					
Health Visitor Contact		Yes	No		
Clarify what child(ren) involved with Health Visitor? Frequency of nursery placements (a.m. /p.m. daily etc.) Summarise priority areas for parent and child joint care planning. If no state why					

School nurse contact –	Yes	No
Specific school concerns? Summarise priority areas for parent and child joint careplanning Homelink involvement Attendance		

Children's Health Issues:	Yes	No
Any current applications to be applied/medications to be dispensed by parent.	Yes	No
Regular Hospital or clinic appointments for child	Yes	No
Any issues in relation to above		
Client's Perceived Effects of their Own or others Alcohol / Drug Use on Children		
Ability to manage income and prioritise everyday bills/household expenditure		
Ability to emotionally respond to children given the potential physical and mental health impact of alcohol/drug use		

Ability to provide activities for children e.g. visits to park, mother and toddler groups
Older children assuming parental role for younger children
What Arrangements are Made for Children when Drug / Alcohol Use Is Being Pursued / Consumed?
Current routines/frequency for alcohol/drug consumption (who with/where/what time)
Discuss areas of potential risk in relation to above and any impact on children. Identify areas of action
Risk from other adults in household

What arrangements are made for Safe Storage of Alcohol / Drugs and associated paraphenalia (both illegal and prescribed)

Where are all medications kept (verify at first HV)

Discuss potential risks from both and summarise

Identify any action to be taken.

Is an appropriate storage box required.

If no identify action e.g. purchase of box. Timescales

Who will purchase

Yes

No

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

When clients stability of alcohol/drug use is obtained how would this change clients lifestyle/parenting

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, ethnicity and disability)	Timescale Include person responsible
IV heroin use mental health - report of auditory hallucinations	methadone program. monitor mental health	completed 8 weeks - tracking - K/W & De Malar, De McMahon, K/W

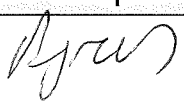
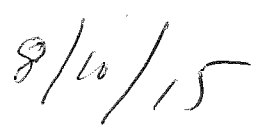
Section 8: ASSESSMENT OUTCOME / INITIAL PLAN OF CARE (contd)

Summary of Assessment

Referred by GP in Feb 2015 for IV heroin use. Failed to attend assessment and went into Christmas Rehab., was to be 18 months but left after 4 months, thought he was ready but quickly relapsed and has been injecting since July/August currently using up to 3 bags daily, and up to 20 street value daily. denies alcohol.

Recently admitted to D/B, auditory hallucinations but discharged due to use on opiate.

Diagnosis of opiate dependency, borderline personality disorder. Continues to report auditory hallucinations but no evidence of harm. Recent suicidal ideations but contracting to safely. Commenced on methadone - to be titrated.

Unmet Need	N/A	Reasons
Client's Perception of the Above		
		
No further action / Referral to other agency (please give details why)		
Service Users Signature:		Date
Assessors Signature:		Date
		

Star Chart

Client:

0502823496

Nesley Philip

Worker:

Jacqueline Leiper

Completed by:

Worker and client

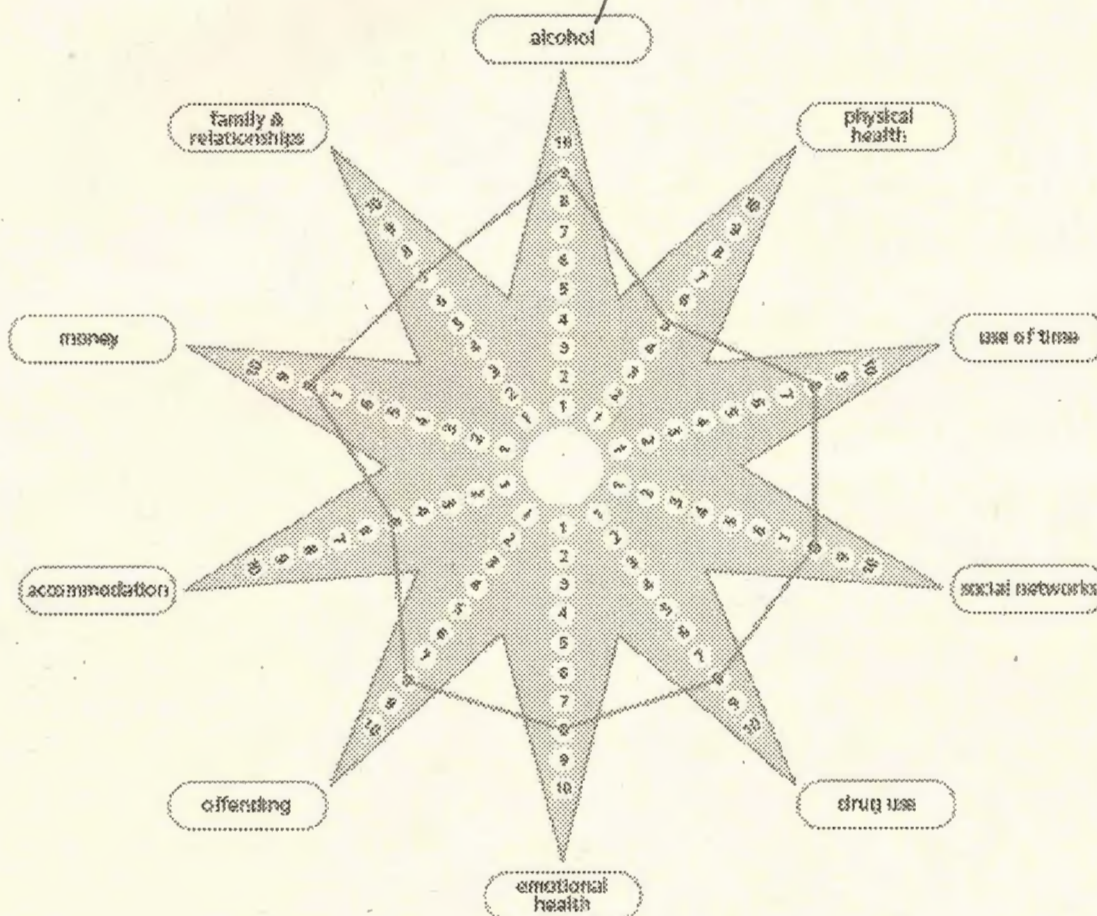
Date completed:

12/01/2016

Retrospective:

No

Review by 12/4/16



Client: I was involved in completing this Star Chart _____

Star Notes

Alcohol

reports nil alcohol
previous alcohol abuse

Physical health

health assesement complete.
ecg.
BBV tested–positive hepc–referred to specialist nurses.

Use of time

spending time at church related activities

Social networks

spending time at church related activities

Drug use

nil heroin for two months. stable on 90mls methadone

Emotional health

mood improved. no current suicidal ideation
prescribed 200mgs

Offending

nil new

Accommodation

has own local authority flat in Paisley. Is considering moving to Greenock to stay with his brother

Money

Has stopped begging since stopped since ceased heroin use.

Family and relationships

improved relations with family—seen over festive period.

Plan

Health	Current score	Next steps	By who?	By when?
	5	Offer initial health assessment including BBV testing/sexual health and pregnancy status (if applicable) -Liaise with general/specialist medical services ie A & E, specialist clinics, to ensure robust communication. -Routine correspondence with GP for initial and ongoing updates, including assessment of existing health needs and treatments. -Offer health promotional information and advice as one to one or in group setting/events. -Offer wound management and harm reduction service where required. -Liaise with medical staff and arrange clinical review at interval less than 3 months. -Obtain routine health investigations ie. Urinary Drug Screens, Alcometer test as standard. -Arrange ECG test for client with high dose Methadone and/or psychotropic medication combinations.	0502823496, Jacqueline Leiper, Dr McMahon/Dr Johnstone(GP)	15 Apr 2016
	8	Offer diversional activity -Recommend attendance at RDS Groups and Recovery Cafe. -Discuss benefits of physical exercise within sphere of capability. -Suggest obtaining diary to arrange day to day events. -Refer to employability/self development service ie Network etc -Refer to RAMH services for group work if appropriate.	0502823496, Jacqueline Leiper	15 Apr 2016

8		-Advertise free events etc locally to encourage confidence. -Encourage set alarm and schedule day.	-work up to prescribing clinic -Meet as required(at least monthly) to offer motivational interviewing, relapse prevention, solution focussed and cognitive based problem solving work ie CBIT. -Offer ongoing risk assessment including overdose awareness and naloxone training. -Discuss Alternatives to Injecting, and reiterate safe injecting practices, encourage less high risk injecting, use of needle exchanges etc. -Offer diversional and occupational activities to develop skills, alleviate boredom and increase confidence. -Liaise with medical staff in medication regimen requires adjustment for safety reasons. - Adhere to child protection policies -Monitor substitute prescribing and liaise with medical staff for planned/unplanned adjustments. -Arrange ECG for clients on QT interval changing medication and high dose Methadone treatment. -Offer education on drug action/interaction/side effect. -Perform drug withdrawal assessments for diagnosis. -Perform routine health assessment to identify needs ie BBV, including pregnancy testing. -Utilise visual aid ie Model of Behaviour Change -Obtain routine Urinary Drug Screen and perform Breath Alcohol testing as standard	0502823496, jacqueline Leiper, Dr McMahon	15 Apr 2016
8		-Complete Glasgow Risk Screen assessment as standard. -Complete Drug Service mental health assessment where mental health issues identified.		0502823496, jacqueline Leiper, Dr	15 Apr 2016

		-Perform PHQ -9, GAD -7 at agreed intervals to measure mood and anxiety. -Liaise with medical staff and report on changes in recovery. -Offer safe-planning/crisis management where required. -Monitor effect/side-effect of neuroleptic medications and inform medical staff timeously. -Liaise with social work if child protection issues re parental mental health issues. -Assess mental health for psychotic symptom each appointment if required. -Ongoing education and relationship between substances and mental and physical ill health. -Offer diversional and occupational activities to develop skills, alleviate boredom and increase confidence. ie referral to mental health resource RAMH etc. -Arrange three monthly medical review with RMO and liaise with updates regularly. -Offer self help cognitive based intervention materials ie CBIT, 5 Areas etc. -Offer wishes and preferences form client. -involve family/relatives where appropriate, and signpost carer's services. -Utilise interfacing guidelines where psychiatric presentation apparent. Utilise crisis management procedure ie, Safe planning, referral to iHTT, FIRST CRISIS, etc and provide helpline numbers local and national. -Offer alternative therapies to assist stress ie auricular acupuncture and signpost stress management services -Attend multidisciplinary meeting ie Care Programme Approach etc as appropriate and communicate timeously between services	McMahon
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Staff _____ Date _____

Star Chart

Client: 0502823496

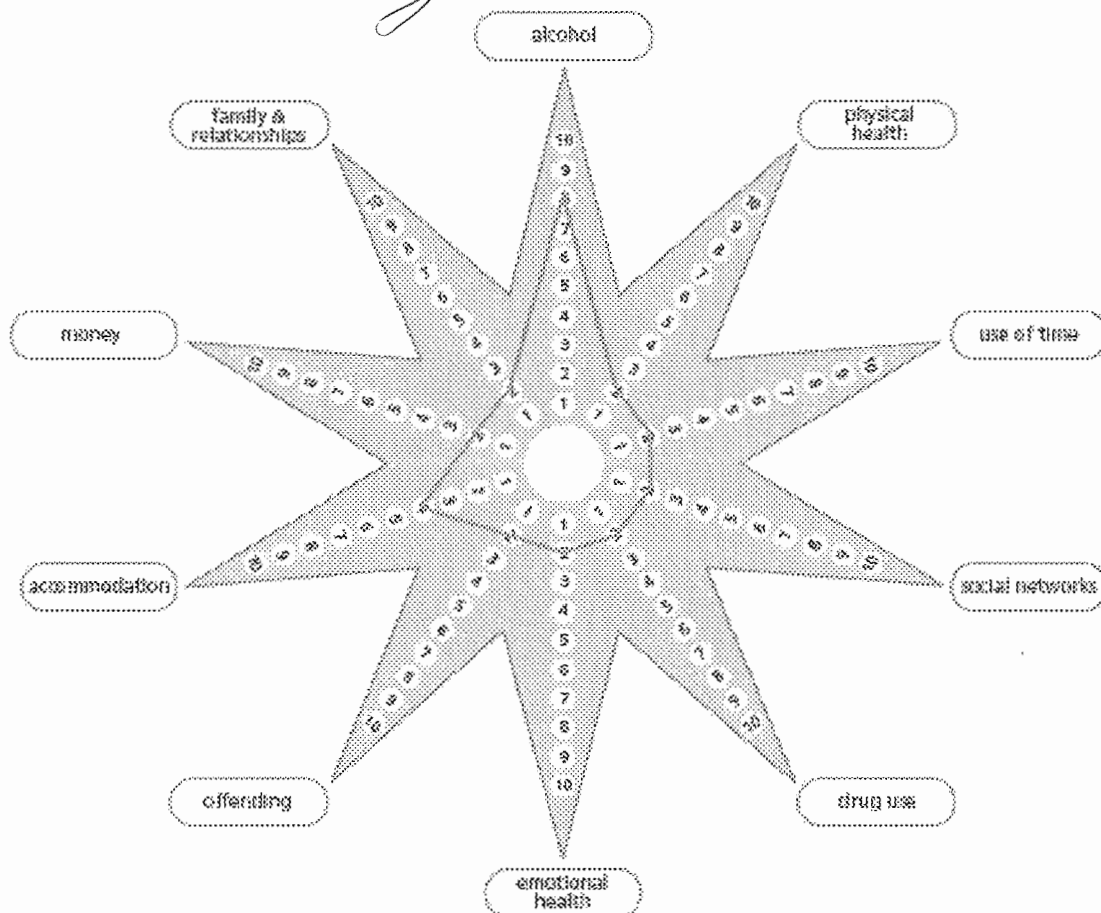
Worker: Jacqueline Leiper

Completed by: Worker and client

Date completed: 08/10/2015

Retrospective: No

Review by 15/1/16



Client: I was involved in completing this Star Chart _____

Star Notes

Alcohol

history of alcohol abuse. states nil at present. requires further investigation

Physical health

iv heroin use into groin. recent needle snapped off in groin, went to a & e, did not remove needle, nore risk to do so. area examine no signs of inflammation.
states hep c positive 2008, states received treatment-no record of same in clinical portal.
pulse 70 and regular.
requires physical health assessment

Use of time

self discharged from rehab July/August 2015. Immediate relapsed on into heroin and diazepam misuse.
no structure to day other than drug use

Social networks

drug using associates, no positive social network

Drug use

long history of iv heroin and illicit diazepam use. poly-substance misuse from a very young age. Previously on methadone, has been to christian rehab on three occasions most recently from March to August this year; was meant to be in for 18months, however, left beliening he would be ok. Immediately returned to substance misuse. Currently using 3 x £10 heroin IV into groin daily and also using illicit diazepam Commenced on methadone today(8/10/15) and to be titrated. Agreed to reduce diazepam.

Emotional health

diagnosis of Tourettes and ADHD as child. diagnosis of borderline personality disorder. previous involvement with IHTT and short i/p admissions. history of self-harm and suicidal ideation. pattern noted that voices suidal thought when percieves that services are not delivering what he wants. recent admission to d/b auditory command hallucinations; discharged as found to be using IV heroin on ward

Offending

history of robbery with weapon, BOP and resisting arrest.
court case in november?

Accommodation

currently living in homeless accommodation.

Money

in debt, all money being spent on drugs.
begging

Family and relationships

fell out with father and brothers.
mother died when he was in cusody.

Plan

Area from	Current score	Next steps	By who?	By when?
Health	2	Offer initial health assessment including BBV testing/sexual health and pregnancy status (if applicable) -Liaise with general/specialist medical services ie A & E, specialist clinics, to ensure robust communication. -Routine correspondence with GP for initial and ongoing updates, including assessment of existing health needs and treatments. -Offer health promotional information and advice as one to one or in group setting/events. -Offer wound management and harm reduction service where required. -Liaise with medical staff and arrange clinical review at interval less than 3 months. -Obtain routine health investigations ie, Urinary Drug Screens, Alcometer test as standard. -Arrange ECG test for client with high dose Methadone and/or psychotropic medication combinations.	0502823496, jacqueline Leiper, Dr McMahon/Dr Johnstone(GP)	15 Jan 2016
	2	Offer diversional activity -Recommend attendance at RDS Groups and Recovery Cafe. -Discuss benefits of physical exercise within sphere of capability. -Suggest obtaining diary to arrange day to day events. -Refer to employability/self development service ie Network etc -Refer to RAMH services for group work if appropriate.	0502823496, jacqueline Leiper	15 Jan 2016

	2	-Advertise free events etc locally to encourage confidence. -Encourage set alarm and schedule day. -work up to prescribing clinic -Meet as required(at least monthly) to offer motivational interviewing, relapse prevention, solution focussed and cognitive based problem solving work ie CBIT. -Offer ongoing risk assessment including overdose awareness and naloxone training. -Discuss Alternatives to Injecting, and reiterate safe injecting practices, encourage less high risk injecting, use of needle exchanges etc. -Offer diversional and occupational activities to develop skills, alleviate boredom and increase confidence. -Liaise with medical staff in medication regimen requires adjustment for safety reasons. - Adhere to child protection policies -Monitor substitute prescribing and liaise with medical staff for planned/unplanned adjustments. -Arrange ECG for clients on QT interval changing medication and high dose Methadone treatment. -Offer education on drug action/interaction/side effect. -Perform drug withdrawal assessments for diagnosis. -Perform routine health assessment to identify needs ie BBV, including pregnancy testing. -Utilise visual aid ie Model of Behaviour Change -Obtain routine Urinary Drug Screen and perform Breath Alcohol testing as standard	0502823496, Jacqueline Leiper, Dr McMahon	15 Jan 2016
lith	2	- Complete Glasgow Risk Screen assessment as standard. -Complete Drug Service mental health assessment where mental health issues identified.	0502823496, Jacqueline Leiper, Dr	15 Jan 2016

			-Perform PHQ -9, GAD -7 at agreed intervals to measure mood and anxiety. -Liaise with medical staff and report on changes in recovery. -Offer safe-planning /crisis management where required. -Monitor effect/side-effect of neuroleptic medications and inform medical staff timeously. -Liaise with social work if child protection issues re parental mental health issues. -Assess mental health for psychotic symptom each appointment if required. -Ongoing education and relationship between substances and mental and physical ill health. -Offer diversional and occupational activities to develop skills, alleviate boredom and increase confidence. ie referral to mental health resource RAMH etc. -Arrange three monthly medical review with RMO and liaise with updates regularly.. -Offer self help cognitive based intervention materials ie CBIT, 5 Areas etc. -Offer wishes and preferences form client. -Involve family/relatives where appropriate, and signpost carer's services. -Utilise interfacing guidelines where psychiatric presentation apparent. Utilise crisis management procedure ie, Safe planning, referral to iHTT, FIRST CRISIS, etc and provide helpline numbers local and national. -Offer alternative therapies to assist stress ie auricular acupuncture and signpost stress management services -Attend multidisciplinary meeting ie Care Programme Approach etc as appropriate and communicate timeously between services	McMahon	
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..... Staff Date

Date:	PROGRESS SHEET NO.:	Worker
18/2/15	Referred by GP - due to concerns - phone call made to offer early appt. however no answer so letter GP IV assessment sent (r 23/2/15 at 1.30pm SM12 to be completed	MB P. [unclear]
23.2.15	Did not attend assessment appointment - no contact received.	
24.2.15	Two week letter sent out to Wesley requesting he make contact - Please see under correspondence. Letter sent to G.P. to inform of same Telephone call to [redacted] using officer - [redacted] message left on answer machine to inform client. did not attend for assessment appointment!	G. Miller
19.3.15	Attended duty - Assessment appointment given for today - at 1.30pm - letter given please see under correspondence. C. Miller	
19/3/15	DNA assessment appointment today. No contact from Wesley.	
29/9/15	Sandra Hamilton (Addiction Nurse) - T/C from Louise (South Ward - Dfebr) 11.40 Reports Wesley admitted to ward yesterday - presenting with auditory and command hallucinations. Was in residential Rehab but left prior to completion of treatment. Referred into IV heroin/buprenorphine and diaspem use after last 2 months. Wesley looking for support/ treatment from LGS Wesley will assess 8/9/15 10am at [unclear] and.	S. Hamilton
8/9/15	T/C message from D. Burre -	D.V. [unclear]

***Client's Name _____	Worker _____
Client's Signature _____	Renfrewshire Drug Service 10 St. James Street Paisley
Date : :	

1. Enter Client's Name (at***) when starting new progress sheet.
2. Initial each entry in right hand margin.
3. Complete box above when client is granted access to personal file.

Date:	PROGRESS SHEET NO.:	Worker
	Wesley being discharged today -	ANJ
	Wesley to attend RD 18am	(JACKIE LEITCH)
8/10/15	8/10/15 for SSA.	ANJ
8/10/15	Message received from [REDACTED]	
8/35	[REDACTED] is adult protection	
	for Wesley - return call [REDACTED]	ANJ
	no answer - message left to	(JACKIE LEITCH)
	return call.	ANJ
	Return call from [REDACTED] - states	
	Sp/ recent Adult Welfare Concern	
	Report - Wesley attended A&E 6/10/15	
	with [REDACTED] needle in groin -	
	x-ray - broken needle seen but no	
	further treatment required. Wesley then	
	left A&E and lay on road,	
	phone now called and he was	
	returned to RAH, then OH	
	hospital, no longer recalled.	
	States will take report to court	
	before decision made.	
8/10/15	Wesley attended, SSA commenced	
1335	- see for details. Received by	
	B McAllister, IV sites checked -	
	PLAN	
	- commence on 30mg miltadone	
	start 8/10/15 7 days - Lloyd's Newbold Rd	
	- clinic 12/10/15 9.40am Dr O'Neil;	
	consider antipsychotic.	
	- requires Leptin BBV testing, -	ANJ
	Naloxone, discuss at next review	(JACKIE LEITCH)
	- SRR25b completed	ANJ
	- TK to A Hallop (GP) informed of	
	outcome.	
	- Wesley to reduce dissection; switch to	
	smoking heroin	

***Client's Name _____	Worker _____
Client's Signature _____	
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Date:	PROGRESS SHEET NO.:	Worker
9/10/15	Help C report note - copy in	
13/15	correspondence - appointment 20/10/15	
	10:30am	CAN
	Risk assessment, discussed and	JACKIE (APR)
	agreed with Jane Bennett (NRL)	JR
12/10/15	Failed to attend	
10/15	T/C to pharmacy - attending no	
	mins	
	message left - Dat note and colleague	CAN
	will visit at home 13/10/15 3:30pm	JACKIE (APR)
	clinic 15/10/15 1500 @ O'Neil	JR
14/10/15	Home visit 13/10/15 cancelled due	
9/10	to crisis with fellow patient	
	T/C to pharmacy report missed	
	one day (12/10/15) only - Message	CAN
	left to attend 15/10/15 1500	JACKIE (APR)
	@ O'Neil script required	JR
15/10/15	Attended clinic with @ O'Neil	
15/15	- see letter in correspondence	
	RSN	
	- methadone to 40mls 7 days	
	- commence quetiapine 2x25mg 7 days	CAN
	- review and scripts 22/10/15	JACKIE (APR)
	11:30am	JR
22/10/15	Attended at this time	
1600	Presentations mental health	
	Slight improvement in presentation	
	a little less distressed	
	Also a little more animated	
	Continued to complain of	
	voices as before	
	Drug Use	
	States no dependency use	
	states has still been taking	
	Dihydrocodeine on top of	

***Client's Name _____	Worker _____
Client's Signature _____	Renfrewshire Drug Service
	10 St. James Street
	Paisley
Date : : _____	

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Date:	PROGRESS SHEET NO.:	Worker
	script	
	Pharmacy health - not seen	
	Shirley Light not seen	
	Optical Care - no children	
	PSN	
	Benita join 22/10/15 #28 days	
	review script BBV 28/10/15	
	13.30pm	
28/10/15	Failed to attend.	
1805	T/C to pharmacy - attending	
	no issues	
	Myra Opt. also attend RDS (JACKIE WICK)	
	for script	
29/10/15	If attends in morbidity to see	
905	if not available - script to be	
	given in the book for Myra and (JACKIE WICK)	
	Next appointment 13.30 4/11/15	
29/10/15	Attended.	
1511	Renfrewshire Mental Health - a little	
	change today shaved. Status not	
	feeling good today as had	
	a burger or heroin (smoked)	
	and 80 x white diarrhoea.	
	yesterday also got his D.L.A.	
	Drug Use - see above	
	Script - BBV testing to be carried	
	out	
	Script/legals has applied for CCG.	
	Child Care - no children	
	PSN	
	review script 4/11/15 1.30pm	
4/11/15	Failed to attend 4/11/15	
1120	T/C to Wesley - agreed to attend	
	5/11/15 14.30 to see Elanir (JACKIE WICK)	
	McHolland for bloods and script	

***Client's Name _____	Worker _____
Client's Signature _____	Renfrewshire Drug Service
	10 St. James Street
	Paisley
Date : :	

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Date:	PROGRESS SHEET NO.:	Worker
5-11-15	Attended appointment - reported he took codeine tablets and elicet blue diazepam tablets. Venous blood obtained for BBV testing. Return appointment given for Results 26/11/15 at 2.30pm. Observed (R) groin Abscess noted - Wesby advised to attend A + E today for assessment + treatment C. Miller (BBV nurse)	
10/11/15	Attended Clinic with Dr McMahon - see file (correspondence) Presc Review, script 11am 13/11/15 Next clinic 15/12/15 11.20am Dr McMahon scripts 10/11/15 7 days as per (DARIE LIPK) Kardex	
17/11/15	Failed to attend - 11/15 1/c to pharmacy - report attending no virus and was away when attended yesterday that he was to attend R28 today for (DARIE LIPK) Prescription	
16/11	Attended Presentation mental health presentation again improved, clear, lucid, more alert. Not complaining of virus today Drug Use States no heroin use for one week Used 2 dihydrocodeine yesterday Physio health To attend to see next week for bloods Spirit/Relig. Living details of CS State well	

***Client's Name _____ Client's Signature _____	Worker _____ Renfrewshire Drug Service 10 St. James Street Paisley
Date : :	

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Date:	PROGRESS SHEET NO.:	Worker
	church & church & voluntary work	
	Child Care - not done	
	Plan	
	- New bus pass requested	
	- Script given for 7 days methadone	AN
	7 days start 17/11/15	(JUNISTARD)
24/11/15	- Review 24/11/15 2.30pm, and script	
11/130	Prescribed as arranged for	
	script	
	Mentation mental health - mentation	
	remains impaired - not complaining	
	of auditory hallucinations - some	
	disturbance to sleep pattern	
	Drug use	
	States not heroin, but has used	
	a few diamorphine	
	Physical	
	- No ill spiritist worse rest	
	and	
	- Self at KMS 8/12/15 1520	
	Social/Agon	
	- Is thinking he may go to	
	London on live & has two	
	brothers stay with there family	
	2 gay & approach housing	
	re Alphas	
	Child Care - not done	
	Plan	
	- script given 7 days start	
	24/11/15	
	- review script 1400 30/11/15	AN
		(GROVE KID)
30/11/15	Failed to attend	
16/10	Plan	

***Client's Name _____	Worker _____
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	10 St. James Street
	Paisley
Date : : _____	

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DATE	PROGRESS SHEET NO.:	Worker
2/11/15	IF attends/contacts - ask to return	(JANE KEMPER)
16/10	1/12/15 1300 to see nurse	JR
11/12/15	Failed to attend.	
16/30	T/C to pharmacy - confirm	
	nurse has been attending -	
	no issues - last attended 3/11/15	(JANE KEMPER)
	and was was to attend	JR
	RDS 1/12/15 to collect script	
	Plan:	
	IF contacts/attends ask to attend	
	2/12/15 - 1400 to see Elaine	
	McKellan - script in letter red	(JANE KEMPER)
	folder	JR
2/12/15	Attended to see human relations	
16/12	nurse.	
	Script given 1/12/15 2 days or	
	per Kardex.	
	Plan	(JANE KEMPER)
	Review script 3pm 7/12/15 3pm	JR
7/12/15	Failed to attend	
16/17	T/C to pharmacy - report attending -	
	no issues.	
	Nurse Off to attend 8/12/15	(JANE KEMPER)
	9.30am the script.	JR
8/12/15	Attended for script - no issues	
12/3	with presentation.	
	Stabs cannot attend for ECT	
	today - rescheduled for 17/12/15 3.30pm	
	Review script 15/12/15 11.20am	JR
15/12/15	Attended clinic with Q & A Makin -	(JANE KEMPER)
1/30	see letter in correspondence for	DARIEL SIRC
	details	
	Plan	
	Script given 2x 2 days start 15/12/15	

Client's Name _____	Worker _____
Client's Signature _____	Renfrewshire Drug Service 10 St. James Street Paisley
Date : : _____	

or Client's Name (at***) when starting new progress sheet.

al each entry in right hand margin.

plete box above when client is granted access to personal file.

Date:	PROGRESS SHEET NO.:	Worker
2/12	as per Kardex	
	date 29/12/15 1 hour appointments	
	next date 9/1/16 1520. B. McMahon	
22/12/15	Attended requesting to be away	
1325	on Christmas to be car with	
	his father. B. McMahon agreed.	
	scripts given:	
	start 24/12 to car 25/-28/12	
	includes	
	Presumptive alcohol of same.	
29/12/15	Failed to attend	
1540	T/c from Wesley, apologising	
	for not attending today -	
	states has nausea and vomiting	
	Wesley states will attend tomorrow	
	morning to collect script	
30/12/15	Attended	
1745	Presentation mental health.	
	again presenting very well.	
	reports improvements in mental	
	health, no current thoughts of suicide /	
	self-harm.	
	Drug use	
	States nil continues to attend	
	relationship meetings.	
	Physical health	
	nil issues reported.	
	Social/legal	
	Continues to attend church.	
	Over doctors zap calling to	
	family that he had not seen	
	in years.	
	Child Care no children	
	Risk	
	scripts given start 29/12/15 2x7 days	

***Client's Name _____ Client's Signature _____ Date : :	Worker _____ Renfrewshire Drug Service 10 St. James Street Paisley
--	---

1. Enter Client's Name (at***) when starting new progress sheet.
2. Initial each entry in right hand margin.
3. Complete box above when client is granted access to personal file.

1. Ent
2. Initia
3. Com

***Client's Name _____ Client's Signature _____	Worker _____ Renfrewshire Drug Service 10 St. James Street Paisley
Date : :	

- SW 19 (07/03)

Date:	PROGRESS SHEET NO.:	Worker
	1/16 to Thouscraigs (housing) report that Wesley announced his transfer on 28/1/16 stating he was going to Kelab in London.	
	Arrived with Abu Bayle (project lead) and 2 McMahon - agreed.	
	1520 contact minute at Bishop's Court on his return. Emma & Lucy and establish Wesley's about message left with Nick Alexander (28/1/16) Phillips to contact with	
	Return call from Alex Phillips confirms that Wesley left for Kelab on Wednesday night.	
	Round with 2 McMahon - case to remain open for a few months in an Le shores	
2/2/16	Miss from church also confirmed that Wesley went to Victoria Outreach in London	
16/2/16	14/4/16 closing summary 0850 Self informed.	
	1st final 18/2/15 - IV Leas use - Diagnosis of Adult Personality Disorder.	
	Failed to engage - case remained open to intake.	
	1/16 received 29/9/16 - Wesley admitted to Bykubas - can attached to wife to follow up.	
	Wesley commenced on Methadone on discharge 4/9/16. Titrated and	

***Client's Name _____	Worker _____
Client's Signature _____	Renfrewshire Drug Service 10 St. James Street Paisley
Date : : _____	

1. Enter Client's Name (at***) when starting new progress sheet.
2. Initial each entry in right hand margin.
3. Complete box above when client is granted access to personal file.

***Client's Name _____ Client's Signature _____ Date : :	Worker _____ Renfrewshire Drug Service 10 St. James Street Paisley
--	---

- SW 19 (07/03)

CONSENT TO SHARE INFORMATION

Person Name	Wesley Phillips		
Identification No.	100-72827	Identification Type*	SWIFT
Worker Name	Alexie Wilson	Designation	CAN

Purpose

This form authorises **Renfrewshire Drugs Service** to share information about you with relevant organisations for the purposes of the ongoing assessment process. We will only share the relevant information required to address your needs. We will only share this information with relevant agencies involved in your care / support.

Statement of Understanding & Agreement

- In order to provide appropriate care / support for me, I understand that information about myself may need to be shared with other relevant organisations who have responsibilities for these supports;
- The reasons why this information is going to be shared, what is being shared and with whom have all been fully explained to me;
- I am aware that I can withdraw my consent at any time although this may affect the support I receive e.g. delay
- I understand I have the right to object to my information being shared with certain individuals / organisations (noted below in 'Comments' section);
- I understand that my consent to share information will be reviewed at my request, or when considered appropriate.

Based upon information explained to me above, I do /do not consent to information about myself being shared with relevant agencies.

Signed: _____ Date: _____

Person / parent / guardian / legally appointed power of attorney

(Delete as appropriate)

Worker Signature: _____ Date: _____

Any Additional Comments: Please note that should there be concerns for any child or adult at risk with whom you have contact then your information will be shared with the appropriate agencies.



0502823496

**PHILLIPS
WESLEY**

05/02/1982 M

Renfrewshire Drug Service
20 Back Sneddon Street
PAISLEY PA3 2DJ
Tel No. 0141 618 2585

**Important Information for those receiving
Methadone-Treatment Contract**

RISK:-

- Methadone is an addictive substance and can cause serious harm or death in overdose.
- Combining Methadone with other drugs and/or alcohol can cause death.
- Methadone can kill those who are not dependent on opiates (do not have a habit).
- Consumption of even a small amount of Methadone is likely to kill a child – even empty containers may contain significant amounts of methadone that could be hazardous to children. Please thoroughly rinse all empty containers before safely disposing of them in household waste.

PERSONAL RESPONSIBILITIES:-

- During Methadone treatment, attendance at a named chemist within the allocated time slots is mandatory and no antisocial behaviour, theft or violence will be tolerated. Should this be reported, treatment will be reviewed.
- Methadone will be administered by the pharmacist on their premises. Alterations to this e.g. For work or holidays may be considered following a period of stability, and any requests to change from daily supervision must be discussed with the key worker and doctor well in advance.

RESPONSIBILITIES IN TREATMENT:-

- Failure to attend appointments and provide urine specimens as requested may mean that prescriptions will be withdrawn.
- Attendance at general practitioners is required for all other medications for physical illness. Opiates, sedatives or sleeping tablets etc, will be discussed at clinic appointment.
- Please behave responsibly at all times whilst attending the project, failure to do so may result in police being called and treatment reviewed.

EXPECTATIONS OF SERVICE FROM RENFREWSHIRE DRUG SERVICE:-

- You will be allocated a key worker where you will mutually agree frequency and venue of appointments.
- You will have regular medical reviews by the prescribing doctor.
- You will be provided information on other services/agencies/supports available and assistance in accessing if required.
- A care plan will be agreed with you and signed by you.

DRIVING:-

The DVLA (Driving Vehicle Licensing Authority) considers drug use, including the use of prescribed drugs, to be a disability. The Road Traffic Act requires drivers to inform the DVLA of any disability likely to affect safe driving. It is your responsibility to inform the DVLA of your drug use (meaning prescribed and/or street drugs) if you intend to drive. You should also report your drug use to your motor insurance company.

DECLARATION:-

I have had the above contract of treatment explained to me and I understand the consequences of it and agree to abide by the conditions within it. I agree to be responsible for my prescription. I will make sure children do not have access to it. I will not supply it to others under any circumstance. I am aware that lost or missed prescriptions will not be replaced.

Client signature.....Date.....
Staff signature..........Date.....

RAM

- will require med for pain
- start methadone
- 1 dose pain
- next week,
- mks dismissed; making home decision; for
- Lloyd's Butcher Rd, 889 2018
- we're quiet, methadone, benzodiazepines

9:30-5:30 } ID taken.
9. -12:30
- done 17/8/15 9:40a

Myra

- needle swapped - given whilst in P/B. As looked X-ray at RPH - could need - still painful
- previous methadone - 90mls. stopped using.
- bus alone. full out with Dad, 2 bottles over last few years
- 1 friend, good support. no partner. no children
- not other needs. no other mms known
- hep C - treatment - cleared.
- Hepatitis tested: no antibodies

Forwards
Nov - outbanding charges

- will square nest for 'wires'
- start mthadone
- > V dosepair
- > nest nest,
- > mths commenced; making brown' downy, fort.
- Myles Nitcher Rd, 889 23MB
- (W) the spates, mthadone, benzodiazepines

9.30-5.30 } 1D take
 9. - 12.30
 - drive 17/8/5 9.40a

Ante/Surgery

Staphed in from

~~last 24th 2014 -> Dec 2014~~

W

~~Christmas Rehab Med 2015 - 1 day~~

~~Unmths August 2015~~

~~left early, brought over~~

~~reading. Staphed mthadone immediately~~

~~4/3 Unmths mthadone in
 3 mthadone - wires - belly line
 god wants him to take her
 on 4th - or inside.
 telling him to beg himself.~~

no alcohol

~~down 20 x daily x every street.~~

~~heres 24th 10 - 11 o'clock~~

~~groin daily~~

DLA / Begging

Port/Singh

Stated in front

~~last Sept 2014~~ → Dec 2014

W

Christmas Rehab March 2015 - 10 days

Unmotivated August 2015

Left early, brought over

reading. Stated wing

~~immediately~~

✓ 4 removed hallucinations
3 weeks - voices - fully in

god wants him to take him
or off - or inside.

!telling him to hang himself!

no alcohol

~~doorstep~~ 20 x daily x every
street.

~~hears 24/7~~ 10-11-12

~~green daily~~

DLA, Begging

ADULT EMERGENCY ASSESSMENT

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

Personal Details

Surname	Phillips	CHI Number	0502823496
Forename & Initial	Wesley	Marital Status	Single
Previous Name(s)		Legal Status	Review Date: / /
Date of Birth	05.02.82	Advanced Statement	Yes ☐ No ☐
Address	Flat 1/4, 17 Abercorn Street	Named Person	
	Paisley	CPA	Yes ☐ No ☒
Post Code	PA3 4AA	Religion	Christian
Telephone No.	0141 848 0859	Present Occupation	
Mobile No.	07591 169 207	Interpreter Required	Yes ☐ No ☐
		Adult at Risk API Form	Yes ☐ No ☐

Risk to Staff:

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

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

REFERRED BY (Name) :- Dr Ejaz

& AGENCY/DESIGNATION :- Out of Hours GP

CONTACT No.-

ASSESSMENT LOCATION: AAU, Dykebar

ASSESSMENT OUTCOME

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

ANY OTHER INFORMATION:

ASSESSED BY -

NAME	Evah Korsah	NAME	Dr Mary Salvia
------	-------------	------	----------------

**ADULT EMERGENCY ASSESSMENT
DYKEBAR HOSPITAL**

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

PRESENTING PROBLEMS AND ASSESSMENT OF RISK

(as expressed by client/carer and assessor):

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

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

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

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

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

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

Appetite – stable.

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

Concentration – okay.

Motivation – lacking motivation and daily structure.

Mood – low.

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

Energy – no recent change.

Denies any psychotic symptoms.

ADULT EMERGENCY ASSESSMENT
DYKEBAR HOSPITAL

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

Long history of Polysubstance misuse.

FORENSIC HISTORY (past and present)

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

MENTAL STATE EXAMINATION

APPEARANCE & BEHAVIOUR:

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

MOOD & AFFECT (Objective & Subjective):

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

SPEECH & THOUGHT FORM:

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

THOUGHT / CONTENT

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

PERCEPTUAL ABNORMALITIES:

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

COGNITION:

Grossly intact.

INSIGHT:

Good.

ADULT EMERGENCY ASSESSMENT
DYKEBAR HOSPITAL

INFORMATION GAINED FROM OTHER SOURCES (collaborative information):
K Drive, GP letter.
CLIENTS EXPECTATION OF REFERRAL/SERVICE (recovery focused):
Admission to hospital.
CARER'S EXPRESSED NEEDS and EXPECTATIONS OF REFERRAL/SERVICE:
None present.
SUMMARY (including impression, identified strengths and risks):
30 year old gentleman well known to RDS presented with suicidal ideation in context of social stressors, inconsistent reports of current drug misuse. No real evidence of pervasive mood disorder. Nil psychotic symptoms. Initially reluctant to guarantee safety but agreed to same by the end of assessment.
RELEVANT STRESSORS:
Threat by father to throw out his dog. Gambling his money.
PROTECTIVE FACTORS:
His dog.
PLAN:
Discussed with SpR Dr McKie, liaise with RDS as regards to management plan for patient. 1. IHTT input and visits to be carried out in Abercorn Street. 2. IHTT need to liaise with Abercorn Street staff to arrange an appropriate room for further assessment/visit/contact due to patient's forensic history. 3. IHTT to call patient afterwards with time of visit. 4. Medical review. 5. ECG, bloods to be arranged. 6. Please liaise with RDS re long term management plan.

**ADULT EMERGENCY ASSESSMENT
DYKEBAR HOSPITAL**

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

HoNOS

- | | | |
|---|--|--|
| 1. Overactive, aggressive, disruptive or agitated behaviour { } | 5. Physical illness or disability problems { } | 9. Problems with relationships { } |
| 2. Non-accidental self-injury { } | 6. Problems associated with hallucinations and delusions { } | 10. Problems with activities of daily living { } |
| 3. Problem-drinking or drug-taking { } | 7. Problems with depressed mood { } | 11. Problems with living conditions { } |
| 4. Cognitive problems { } | 8. Other mental and behavioural problems { } | 12. Problems with occupation and activities { } |

TOTAL { }

**ADULT EMERGENCY ASSESSMENT
DYKEBAR HOSPITAL**

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

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

CURRENT MEDICATION

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

ATTITUDE TOWARDS MEDICATION (including history of concordance):

Not sure, does not feel it is working.

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

Medications stopped by RDS due to abnormalities in ECG results.

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

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

**ADULT EMERGENCY ASSESSMENT
DYKEBAR HOSPITAL**

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

Single Shared Assessment

Drug / Alcohol Support Needs Assessment Package

17 November 2006: Version 10

Person's Name:

Wesley Phillips

TEL: -
0141 570 2692 .

Person's DOB:

05-02-1982

Lead Assessor's Name:

Elaine McEwan

Agency of Lead Assessor:

East Ren CAT

Date of Assessment:

13-9-11

Date of Review:

Date of Review:

Date of Review:

Mental Health Partnership
Clinical Risk Screening and Management Tool

Service Users Name: Wesley Phillips	CHI N°/DoB: CHI: D.O.B 0502823496	PIMS N°:
Legal Status: Informal ☐ Detained ☐ Community Order ☐	Ward /Dept / CMHT: RDS	

Context of Assessment

On admission ☐	Engagement with Crisis Services ☐	MDT/C.P.A. review ☐
Annual review: ☐ Significant change in presentation/circumstances ☐ Other ☐ specify		

Sources of Information

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

Guidance

This screening form should be completed as fully as possible. It is a clinical judgement when this should take place however as a general guide this may be on admission to hospital or at the point of engagement with secondary mental health services. Thereafter it should be reviewed on a regular basis as pre-determined by the clinical team or as significant changes in circumstances or clinical presentation dictate. It is expected that reviews would routinely take place at multidisciplinary meetings, the point of transition from one aspect of service to another, as part of a planned annual review, at the point of CPA review, at the point of engagement with Crisis Services. In relation to admissions to hospital, the initial screening and formulation of risk should be reviewed at the next multi-disciplinary team meeting.

- Dependant on the information collected consideration should be given to carrying out a more detailed, specific risk assessment e.g. suicide risk assessment.
- This document should form an integral part of a comprehensive mental health assessment and care planning process, and the factors listed are not necessarily in any ranked order.
- This does not attempt to be an exhaustive list of safety issues or risk factors, merely an initial guide informing clinical management.
- The expectation that all safety risks can be predicted is unrealistic, and initial assessment may be based on incomplete information.
- If completed by one person (e.g. out of hours), this assessment should be discussed as soon as is practicable with the Consultant and multi-disciplinary team (including users and carers where appropriate).
- The assessment should include the service user and carer perspective of risk.
- The assessment must take account of parenting responsibilities and contact with children.
- Please refer to the Clinical Risk Screening & Management Policy for guidance.

Screening completed by

Print Name: MS Parkinson	Signature: MS Parkinson
Designation: Community addition nurse	Date & Time: 3/6/14

NHS
Greater Glasgow
and Clyde

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Mental Health Partnership
Clinical Risk Screening and Management Tool

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

Management plan	Action by:
Suicide/Self Harm Refer to IHTT in MAY Wesley did not make RDS aware of this	
Violence - None - Behaviour appropriate at RDS	
Other Risk Factors - If GAMBLING, CAUSES STRAIN WITH FATHER. CAN THEN LEAD TO Wesley failing to cope. - He is aware of R-C.A for GAMBLING & HAS ATTENDED THIS SERVICE - NOT GAMBLING AT present	

Outcome of screening/management plan discussed with

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

Management Plan completed by

Print Name: MS Parkinson	Signature: MS [Signature]
Designation: community addiction nurse	Date & Time: 3/6/14

NHS
Greater Glasgow
and Clyde

[illegible]

RDS PHYSICAL HEALTH ASSESSMENT

NAME <i>Wesley Phillips</i>	DOB <i>5.2.82.</i>	CHI NUMBER
ASSESSOR <i>Kioni</i>	DATE <i>6/9/13</i>	KEYWORKER <i>Maya</i>
KNOWN ALLERGIES/HISTORY OF ANAPHYLAXIS <i>No known allergies</i>		
Urine Drug Test Record – sample sent to lab for confirmation:- YES/NO +VE -VE		
Alco meter reading- <i>0</i> Alcohol consumption - including drink of choice, how much, pattern of use <i>- less than once a week - doesn't drink</i> History of withdrawal – including tremors, sweats, seizures, DTs <i>O.T's in past ??</i>		

BP- <i>110/70</i>	Height- <i>6ft 3</i>	Weight- <i>120kg</i>	MUST Score (if required)- <i>1</i>
Pulse- <i>72</i>	BMI- <i>33</i>	Action taken- <i>weekly weight</i>	
Urinalysis result			
Routine Bloods	<i>Taken</i>		
Signs of IV use- YES/NO	History of IV use- YES/NO	DVT Referral leaflet given YES/NO YES/NO	
Signs of DVT- YES/NO	History of DVT- YES/NO		
Sign of Abscess/Cellulitis YES/NO YES/NO	Location-	Action taken-	
ECG Testing required- <i>K/w</i>	YES/NO YES/NO	Appointment made YES/NO DATE-	

*6ft 3
120kg*

MEDICAL HISTORY - including recent admissions, surgery, overdose, seizures, diabetes, family history etc

Mother [REDACTED]

No FH strokes, cancer, diabetes.

operation to (R) index finger.

	YES	NO	DETAILS
Are you currently prescribed any medication?	☒	☐	Sertraline.
Are you currently taking any over the counter medication?	☐	☒	
Do you see any other health professionals?	☐	☒	

BLOOD BORNE VIRUS

Have you ever been tested for:-	Yes	No	ACTION TAKEN
Hepatitis B	☒	☐	
Hepatitis C	☒	☐	Stated treated successfully for HCV infection 5 years ago.
HIV	☒	☐	
Have you put yourself at risk since your last test?	☐	☒	Blood obtained to recheck.
Have you previously been vaccinated for Hep A & B?	☒	☐	
HEPATITS B TITRE	☒	☐	
IMMUNISATION STATUS			
BBV Referral Completed	YES/NO		

SEXUAL HEALTH

	YES	NO	DETAILS
Are you currently sexually active?	☒	☐	
What method of contraception do you use?	☒	☐	Condoms
Female Questions Only	YES	NO	DETAILS
Is your menstrual cycle regular? (please ask when last menstruated)	☐	☐	
Menopause?	☐	☐	
Are you pregnant?	☐	☐	
Pregnancy Test carried out?	☐	☐	
When was your last smear?	☐	☐	
Other info-			

NALOXONE

	YES	NO	DETAILS
HAVE YOU EVER SUFFERED / TAKEN AN OVERDOSE	☐	☒	
HAVE YOU EVER SEEN AN OVERDOSE	☒	☐	
NALOXONE INFORMATION GIVEN	☒	☐	
NALOXONE TRAINING DATE GIVEN	☒	☐	
NALOXONE SUPPLY GIVEN	☒	☐	
Other info-			

CHECKLIST FOR SUBOXONE

MULTIPLE ILLICIT DRUG OVERDOSE +/- ALCOHOL	
CHAOTIC POLYDRUG MISUSE WITH HIGH RISK OF OVERDOSE	
ALCOHOL DEPENDANCY	
SIGNIFICANT CARDIAC PROBLEMS	
CHRONIC CHEST / LUNG PROBLEMS	
PREVIOUS HIGH LEVELS OF METHADONE MAINTENANCE (>130)	
PREVIOUS INTOLERANCE TO METHADONE (OVERSEDATION/DROWSY)	
PREVIOUS PERSISTENT UNWANTED SIDE EFFECTS TO METHADONE	
PREVIOUS CONTINUED OPIATE MISUSE DESPITE ADEQUATE METHADONE MAINTENANCE	
HISTORY OF SEIZURES	
CURRENT ANTICONVULSANT MEDICATION (EPILEPSY / BI POLAR)	
CURRENT TREATMENT FOR HCV / HIV / AIDS / TB	

Nutrition Profile

Name:		Date of admission: 6/9/13
Address:	0502823496 WESLEY PHILLIPS 48 BRAESIDE DRIVE BARRHEAD G78 2QB 05/02/1982	Time: 10am
DoB:		HOSPITAL: RDS
CHI number:		Ward:
Affix patient data label		

To be recorded within 24 hours of admission*

Height: 6ft	m/ft 3	Actual ☒ Patient/ carer reported ☐ Alternative measurement ☐
Weight: 120	kg/stones	Actual ☒ Patient/ carer reported ☐ Alternative measurement ☐
Recent unplanned weight loss: Yes ☒ No ☐		
If 'Yes' how much?: 3 kg/stones. Over what period of time?: 3 weeks/months		
Is there evidence of recent weight loss? No ☐ Loose clothing ☒ History of reduced food intake/appetite ☐ Swallowing problem ☐		
Eating and drinking likes and dislikes (including appetite and/or NBM status): No issues - lost appetite as he was not buying food spending money on gambling		
Dietary requirements (e.g. vegetarian; texture modified diet and fluids; halal; kosher) Yes ☐ No ☒ Please state:		
Are there any contributing factors that may affect food intake such as physical (e.g. swallowing difficulties), physiological (e.g. nausea), psychological (e.g. dementia), social or environmental ? Yes ☐ No ☐ Please specify all factors: - spending money on other activities		
Is there a need for equipment and/or assistance with eating and drinking? Yes ☐ No ☒ Please state:		
Profile completed by: Name (PRINT): K. V. Signature: [Signature] Date: 6/9/13		

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

Malnutrition Universal Screening Tool ('MUST')

Date

6/9/16

Initials

h

Height (see page 1)

Weight

170

Oedema or ascites present Y/N

N

BMI

30

'MUST'

Step 1: BMI Score (refer to chart on page 4)

20 (>30 = Obese) 0
18.5 - 20 1
<18.5 2

0

Step 2: Weight Loss Score

Unplanned weight loss in past 3-6 months:

<5% 0
5-10% 1
>10% 2

?

1

Step 3: Acute Disease Effect Score

If patient is acutely ill **and** there has been or is likely to be no or virtually no food intake for > 5 days..... Score 2

Not applicable Score 0

0

Step 4: Overall Risk of Malnutrition

Total:

1

Step 5: Management Guidelines

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

Step 2 - Weight Loss Score

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

Height (feet and inches)

53	54	54½	55	56	57	57½	58	59	510	511	511½	60	61	62	63
39	38	37	36	35	34	33	32	31	30	29	28	27	26	25	24
38	37	36	35	34	33	32	31	30	29	28	27	26	25	24	23
37	36	35	34	33	32	31	30	29	28	27	26	25	24	23	22
36	35	34	33	32	31	30	29	28	27	26	25	24	23	22	21
35	34	33	32	31	30	29	28	27	26	25	24	23	22	21	20
34	33	32	31	30	29	28	27	26	25	24	23	22	21	20	19
33	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	16
30	29	28	27	26	25	24	23	22	21	20	19	18	17	16	15
29	28	27	26	25	24	23	22	21	20	19	18	17	16	15	14
28	27	26	25	24	23	22	21	20	19	18	17	16	15	14	13
27	26	25	24	23	22	21	20	19	18	17	16	15	14	13	12
26	25	24	23	22	21	20	19	18	17	16	15	14	13	12	11
25	24	23	22	21	20	19	18	17	16	15	14	13	12	11	10
24	23	22	21	20	19	18	17	16	15	14	13	12	11	10	9
23	22	21	20	19	18	17	16	15	14	13	12	11	10	9	8
22	21	20	19	18	17	16	15	14	13	12	11	10	9	8	7
21	20	19	18	17	16	15	14	13	12	11	10	9	8	7	6
20	19	18	17	16	15	14	13	12	11	10	9	8	7	6	5
19	18	17	16	15	14	13	12	11	10	9	8	7	6	5	4
18	17	16	15	14	13	12	11	10	9	8	7	6	5	4	3
17	16	15	14	13	12	11	10	9	8	7	6	5	4	3	2
16	15	14	13	12	11	10	9	8	7	6	5	4	3	2	1
15	14	13	12	11	10	9	8	7	6	5	4	3	2	1	0
14	13	12	11	10	9	8	7	6	5	4	3	2	1	0	-1
13	12	11	10	9	8	7	6	5	4	3	2	1	0	-1	-2
12	11	10	9	8	7	6	5	4	3	2	1	0	-1	-2	-3
11	10	9	8	7	6	5	4	3	2	1	0	-1	-2	-3	-4
10	9	8	7	6	5	4	3	2	1	0	-1	-2	-3	-4	-5
9	8	7	6	5	4	3	2	1	0	-1	-2	-3	-4	-5	-6
8	7	6	5	4	3	2	1	0	-1	-2	-3	-4	-5	-6	-7
7	6	5	4	3	2	1	0	-1	-2	-3	-4	-5	-6	-7	-8
6	5	4	3	2	1	0	-1	-2	-3	-4	-5	-6	-7	-8	-9
5	4	3	2	1	0	-1	-2	-3	-4	-5	-6	-7	-8	-9	-10
4	3	2	1	0	-1	-2	-3	-4	-5	-6	-7	-8	-9	-10	-11
3	2	1	0	-1	-2	-3	-4	-5	-6	-7	-8	-9	-10	-11	-12
2	1	0	-1	-2	-3	-4	-5	-6	-7	-8	-9	-10	-11	-12	-13
1	0	-1	-2	-3	-4	-5	-6	-7	-8	-9	-10	-11	-12	-13	-14
0	-1	-2	-3	-4	-5	-6	-7	-8	-9	-10	-11	-12	-13	-14	-15
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-3	-4	-5	-6	-7	-8	-9	-10	-11	-12	-13	-14	-15	-16	-17	-18
-4	-5	-6	-7	-8	-9	-10	-11	-12	-13	-14	-15	-16	-17	-18	-19
-5	-6	-7	-8	-9	-10	-11	-12	-13	-14	-15	-16	-17	-18	-19	-20
-6	-7	-8	-9	-10	-11	-12	-13	-14	-15	-16	-17	-18	-19	-20	-21
-7	-8	-9	-10	-11	-12	-13	-14	-15	-16	-17	-18	-19	-20	-21	-22
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-19	-20	-21	-22	-23	-24	-25	-26	-27	-28	-29	-30	-31	-32	-33	-34
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-41	-42	-43	-44	-45	-46	-47	-48	-49	-50	-51	-52	-53	-54	-55	-56
-42	-43	-44	-45	-46	-47	-48	-49	-50	-51	-52	-53	-54	-55	-56	-57
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-55	-56	-57	-58	-59	-60	-61	-62	-63	-64	-65	-66	-67	-68	-69	-70
-56	-57	-58	-59	-60	-61	-62	-63	-64	-65	-66	-67	-68	-69	-70	-71
-57	-58	-59	-60	-61	-62	-63	-64	-65	-66	-67	-68	-69	-70	-71	-72
-58	-59	-60	-61	-62	-63	-64	-65	-66	-67	-68	-69	-70	-71	-72	-73
-59	-60	-61	-62	-63	-64	-65	-66	-67	-68	-69	-70	-71	-72	-73	-74
-60	-61	-62	-63	-64	-65	-66	-67	-68	-69	-70	-71	-72	-73	-74	-75
-61	-62	-63	-64	-65	-66	-67	-68	-69	-70	-71	-72	-73	-74	-75	-76
-62	-63	-64	-65	-66	-67	-68	-69	-70	-71	-72	-73	-74	-75	-76	-77
-63	-64	-65	-66	-67	-68	-69	-70	-71	-72	-73	-74	-75	-76	-77	-78
-64	-65	-66	-67	-68	-69	-70	-71	-72	-73	-74	-75	-76	-77	-78	-79
-65	-66	-67	-68	-69	-70	-71	-72	-73	-74	-75	-76	-77	-78	-79	-80
-66	-67	-68	-69	-70	-71	-72	-73	-74	-75	-76	-77	-78	-79	-80	-81
-67	-68	-69	-70	-71	-72	-73	-74	-75	-76	-77	-78	-79	-80	-81	-82
-68	-69	-70	-71	-72	-73	-74	-75	-76	-77	-78	-79	-80	-81	-82	-83
-69	-70	-71	-72	-73											

REFERRAL

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

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

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

Reason for Referral:

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

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

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

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

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

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

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

States overdose was not full attempt to end his life...retains insight...more a cry for help from services.

Following discussion with on-call SPR.

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

Information provided for gamblers anonymous and crisis numbers

Referred By: EMCGEE // B. GIBSON

Location: Charleston centre

Designation: IHTT

Contact Information/Number: 618 3333

Date Referred: 26/10/14

Email to: healthrecords.dykebarhospital@ggc.scot.nhs.uk



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



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

PRIVATE & CONFIDENTIAL

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

Dear Dr Johnston

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

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

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

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

Yours sincerely

Eddie McGee
Intensive Home Treatment Practitioner
Intensive Home Treatment Team

20 Back Sneddon Street
PAISLEY PA3 2DJ

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

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

PRIVATE & CONFIDENTIAL

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

Dear Dr Johnstone

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

Psychiatric Diagnosis: F11.2 – Opiate Dependence

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

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

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

Yours sincerely

Dr Claire Duncan,
ST3 in Addiction Psychiatry

Dr Charles McMahon
Consultant Psychiatrist



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



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

PRIVATE & CONFIDENTIAL

Dr Johnstone
Barony Medical Practice
Northcroft Medical Centre
Paisley

Dear Dr Johnstone

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

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

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

Yours sincerely

Desmond McPeake
Senior Intensive Home Treatment Practitioner
Intensive Home Treatment Team

Cc Margaret Parkinson / Dr McMahon, RDS

RENFREWSHIRE DRUG SERVICE
Back Sneddon Centre
20 Back Sneddon Street
Paisley
PA3 2DJ

Tel No: 0141 618 2585

Date: 14/04/2016

Dr Johnstone
Barony Practice
Northcroft

Private and Confidential

RE: Wesley Philips 05/02/1982 3496.

Dear Dr Johnstone,

Mr Philips ceased treatment with ourselves and entered a Christian Rehab in England There has been no contact from Mr Philips and therefore his case has now been closed to RDS.

Should you feel that Mr Phillips requires the service in the future, please to do not hesitate to refer him.

If you require any further information please do not hesitate to contact me on the above number.

Yours sincerely,

A handwritten signature in black ink, appearing to be 'Jackie Leiper', with a stylized, flowing script.

Jackie Leiper (Community Addictions Nurse).

Renfrewshire Drug Service

Date: 17th February 2016
Date Dictated: 9th February 2016
Our Ref: CMcM/SR/0502823496
Enquiries: Renfrewshire Drug Service
Tel: 0141 618 2585

PRIVATE & CONFIDENTIAL

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

Dear Dr Johnstone

Wesley Phillips, DoB: 05.02.1982, 0/2, 51 Thrushcraig Crescent, Paisley, PA2 6PP

Psychiatric Diagnosis: Opiate Dependence, Disorder of Adult Personality

Current Psychotropic Medication: Currently Not on Medication

I was due to see Wesley Phillips today but he did not come. As far as we can ascertain he has taken himself off to some kind of third sector, a Christian rehabilitation centre in England. He had mentioned this to staff briefly and we had also telephoned his father who confirmed as far as he is aware this is where Wesley is.

We will await contact on his release.

Yours sincerely

Dr. Charles McMahon
Consultant Psychiatrist

c.c. Jacqueline Leiper, Key Worker, Renfrewshire Drug Service

Renfrewshire Drug Service

Date: 13th January 2016
Date Dictated: 16th December 2015
Our Ref: CMcM/SR/0502823496
Enquiries: Renfrewshire Drug Service
Tel: 0141 618 2585

PRIVATE & CONFIDENTIAL

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

Dear Dr Johnstone

Wesley Phillips, DoB: 05.02.1982, 0/2, 51 Thrushcraig Crescent, Paisley, PA2 6PP

Psychiatric Diagnosis: Opiate Dependence, Disorder of Adult Personality

Current Psychotropic Medication: Methadone 80mls daily, Quetiapine 200mgs daily

I saw Wesley for further review at the Drug Clinic on the 15th December 2015. He appears to be settling down. He said that he hasn't been using heroin or valium for the last month. The relationship with his father has improved. He is attending various church groups and fellowship meetings. He looked clean and tidy and much more coherent today.

He is confident that he can get himself safely through the festive period. He did mention however that he is thinking about doing one of the voluntary sector rehabilitation units again, given his history and coexistent psychological difficulties, a rapid detox in a non statutory rehabilitation centre is unlikely to be helpful but we will talk to Wesley about this in the new year.

I will let you know how things progress.

Yours sincerely

Dr. Charles McMahon
Consultant Psychiatrist

✓ c.c. Jacqueline Leiper, Key Worker, Renfrewshire Drug Service

RDS Outreach HCV Assessment Clinic

Date of Referral:

<u>Name</u>	<u>CHI Number</u>	<u>DOB</u>
Wesley Philips	0502823496	05/02/1982
<u>Home Address</u>	<u>GP and Address</u>	<u>Name of Referrer</u>
14F Thrushcraigs Crescent Paisley PA2 6PN	Dr Johnstone, Barony Practice Northcoft	Jackie Leiper
		<u>Name of Prescribing Dr.</u>
		Dr McMahon
<u>Current Treatment /Medication</u>		
Methadone 90mls, quetiapine 200mgs		
<u>Pharmacy Details & Dispensing regime</u>		
Daily supervised at Lloyds, Neilston Rd.		
<u>Patient background including medical history/mental health issues etc.</u>		
Long history of opiate dependence(IV heroin) currently stable on methadone. Diagnosis of Adult Personality; previous admissions to Dykebar with suicidal ideation and auditory hallucinations. Mental health stable at present.		
<u>Any other relevant information</u>		
<u>Waverley care referral discussed</u> xYES/NO		

Please e-mail new referrals to:

Renfrewshire Drug Service

Date: 17th November 2015
Date Dictated: 10th November 2015
Our Ref: CMcM/DJC/CHI 050282 3496
Enquiries: Renfrewshire Drug Service
Tel: 0141 618 2585

PRIVATE & CONFIDENTIAL

Dr Johnstone
Barony Medical Practice
Northcroft Medical Practice
Northcroft Street
PAISLEY
PA3 4AD

Dear Dr Johnstone

Wesley Phillips, dob 05.02.82 – 0/2, 51 Thrushcraig Crescent, Paisley, PA2 6PP

Psychiatric Diagnosis: Opiate Dependence, Disorder of Adult Personality

Current Psychotropic Medication: Methadone increased to 80mls daily, Quetiapine 200mgs daily

I saw Wesley for further review at Renfrewshire Drug Clinic on 10.11.15. Wesley unfortunately has continued to use heroin including by injection. He has had several problems including a needle stuck in his groin which has come out spontaneously and also possibly an abscess although he now has attended A & E about these.

He said that he has reduced but not stopped his heroin use and I have increased his Methadone today.

Despite this he actually looked relatively well today. He looked reasonably well kempt and well nourished. He said he is looking after himself. He is quite isolated but perhaps being away from other drug users is a good thing. Wesley as he always has done is using the supports in the local churches and I have encouraged him to also try and get involved with the recovery activities.

He reports continuing to be troubled by voices but in a pretty half hearted way acknowledging that they are not frequent or intrusive or particularly troubling at the moment. He requested a further increase in his Quetiapine and I have increased that to 200mgs daily. We will check an ECG.

Yours sincerely

Dr. Charles McMahon
Consultant Psychiatrist

c.c. Jacqueline Leiper, keyworker, Renfrewshire Drug Service

20 Back Sneddon Street
Paisley PA3 2DJ

Date: 19 October 2015
Date Dictated: 15 October 2015
Our Ref: BO'N/KAC/CHI 0502823496
Enquiries: Renfrewshire Drug Service
Tel: 0141-618-2585

Private & Confidential

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

Dear Dr Johnstone

Wesley Phillips (0502823496)
14/5 Thrushcraigs Crescent, Paisley PA2 6PW

Psychiatric Diagnosis: Opiate Dependence Syndrome, previous diagnosis of Borderline Personality Disorder

Current Psychotropic Medication: Methadone 40 mls daily supervised, Quetiapine 50 mgs (commenced today)

.....
I reviewed this gentleman at Renfrewshire Drug Service on 15 October along with his key worker Jackie Leiper following initiation of Methadone last week.

He presented on time and like the previous week, was unkempt, unshaven and smelly. He did not appear intoxicated but his manner was quite lugubrious and bordered on loco-motor retardation. He continues to report consistently the same auditory and visual hallucinations as previously documented. In a review of his case record, this has been consistent over the last 3 years. He admits to suicidal ideation which often peaks when the 'voices' are at their most active. He has no plans to kill himself today although this has not been the case recently prior to his admission to Dykebar hospital.

He is happy that he has been established on Methadone and feels that it could help him. He reports having last used 0.4 grams of heroin, injected into the groin 5 days ago. On 2 days this week he used approximately 90 mgs of Dihydrocodeine both days. He considers this a substantial improvement.

He denies any Valium use since his admission to Dykebar and we shall corroborate this with a urine drug screen although quite late in the interview he admitted to taking 10 mgs of Mogadon to enable sleep.

After discussion, which verified the reporting from previous years, we agreed that perhaps commencing an anti-psychotic might be useful. He informed me today that there have been occasions when the voices have been absent and this has been associated with him desisting from drug use and being compliant with his medication. We commenced him on Quetiapine 50 mgs initially and shall review him early and regularly.

Cont/.....

Page 02
Wesley Phillips

Dr Johnstone
The Barony Practice

I note that he also reports the remaining portion of the needle spontaneously removed itself from his groin.

We shall keep you updated as to his progress.

Yours sincerely

Dr Brian O'Neill
Specialty Doctor
Addiction Psychiatry

Dr Charles McMahon
Consultant Psychiatrist

cc: Jackie Leiper, RDS ✓

Renfrewshire Drug Service

Date: 9th October 2015
Date Dictated: 8th October 2015
Our Ref: MMcC/DJC/CHI 050282 3496
Enquiries: Renfrewshire Drug Service
Tel: 0141 618 2585

PRIVATE & CONFIDENTIAL

Dr Johnstone
Barony Medical Practice
Northcroft Street
Paisley
PA3 4AD

Dear Dr Johnstone

Wesley Phillips, dob – 05.02.82, 14/5 Thrushcraig Crescent, PA2 6PW

Psychiatric Diagnosis: F11.22 – Opiate Dependency

Previous Diagnosis: Borderline Personality Disorder

Current Psychotropic Medication: Methadone 30mls (daily supervised- commenced today)

I met with Wesley at the Renfrewshire Drug Service on 08.10.15. As you will be aware he had been previously admitted to Dykebar following an episode of auditory hallucinations however he had been asked to leave Dykebar prior to the assessment period ending as he had been found to be injecting Heroin while on the ward. Unfortunately things were made slightly more complicated when a needle snapped and remained in situ. He attended Accident & Emergency for an x-ray to confirm the presence of the broken needle and was reviewed by the consultant there. I understand they feel that no action is required at present.

Wesley was able to give me a detailed account of the last few months. He spent some time in custody and following his release attended a Christian Rehab Centre. This was to be an 18 month rehab but he left after 4 months. While there he ceased all anti psychotic therapy and on returning home recommenced illicit opiate use. He has been injecting since July. I understand you have encouraged him to attend RDS and that he is also being reviewed at Dykebar.

He is currently injecting up to three bags daily and is not on any other medication. He resides in a homeless flat and is also consuming up to 20 street valiums on a daily basis. He is not drinking any alcohol and I understand he had been treated with Dihydrocodeine whilst in Dykebar. He has previously done well on Methadone.

Today he was dressed in rather dirty clothes and was slightly unkempt although he did appear to have washed. His test was clear and although he was slightly overweight his abdominal examination was unremarkable. I took the opportunity to inspect for any infected injection sites and there were none. Indeed the site in his groin where he had the accident with the needle was healing well with lower limbs and good peripheral pulses and no adima.

Cont/.....

Wesley Phillips, dob – 05.02.82, 14/5 Thrushcraig Crescent, PA2 6PW

- 2 -

Today Wesley stated that the voices were very clearly inside his head however he was not sleeping well. Today he spoke quietly but did not appear to be unduly distressed or anxious nor responding to any hallucinations. I understand there had been an episode where he had lain in the road. It would appear that he had certainly reached a point where he requires some treatment for his current mental state. Today he seemed amenable to opiate replacement therapy. We discussed the risk of overdose and encouraged him to move from injecting to smoking. We also highlighted the risks of illicit valium and he assures us that if this may be causing a decline in his mental state that he will reduce the valium and stop them.

In the first instance we have agreed a plan to stabilise him on Methadone and have commenced him on 30mls on a daily supervised dose and suggest that he meets with his worker next week. He is reluctant to recommence Aripiprazole but would be amenable to Quetiapine. I advised that as he stabilises on Methadone we will consider this. I will keep you updated of any further developments.

Yours sincerely

Dr Melanie McCallum
Medical Officer


Dr Charles McMahon
Consultant Psychiatrist 

c.c. Jacqueline Leiper, keyworker, Renfrewshire Drug Service ✓

Hepatitis C Clinic
Referrals from RDS

<u>Name</u>	<u>CHI Numbers</u>	<u>DOB</u>
Wesley Philips	0502823496	05/02/1982
<u>Home Address</u>	<u>GP and Address</u>	<u>Name of Referrer</u> <u>Jackie Leiper</u>
0/1 51 Thrushcraigs Crescent Paisley, PA2 6PP	DR Johnstone Barony Practice Northcroft	<u>Name of Dr</u> <u>DR McMahon</u>
<u>Current Treatment /Medication</u> <u>Commenced on methadone 30mls on 8/10/2015-to be titrated.</u>		
<u>Patient background including medical history/mental health issues etc.</u> States Hep C diagnosis in 2008, states got treatment-no record in clinical portal. Continued IV heroin use. Diagnosis of emotionally unstable personality disorder, recent reports of command hallucinations and suicidal ideation. Discharged from di/p at Dykebar due to IV use on ward. Commenced on methadone, currently being titrated.		
<u>Any other relevant information</u> <u>Date & time of Appointment given to patient</u> <u>20/10/2015 1030am.</u> <u>Waverley care referral:</u>		

Please e-mail new referrals with **date of appointment** to:

and add patient name to duty diary on date and time of appointment issued.

Appointment start 9.30am. Last appointment 10.45am