

PiMS P1518904

Nursing, Psychological Therapy and Allied Health Professional Notes

- Please use these notes sheets continuously, writing in chronological order, and ensuring that the date, time (24 hour clock), signature and designation are detailed for all staff involved in the care of the patient. If separate professional notes are held elsewhere, staff should still write a summary of their contact below.
- Please include details of the Outcomes Plan evaluation, investigations, assessments, changes in legal, risk or observation status and communication with carers and relatives.

Sheet

Number:

* Please print name and designation under signature the first time you write in the notes. Future entries need only be signed.

Signature*

[illegible]

NHS Lanarkshire Mental Health Services
Generic Integrated Care Pathway (Inpatient)

Shaw, Andrew
DOB: 21/04/1967 Male
No Fixed Abode

Medical Notes

(including Clinical Pharmacy Notes if required)

NF1 1AB
PiMS P1518904

Instructions for use:

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- Please include details of investigations, assessments, changes in legal, risk or observation status and communication with carers and relatives.

Sheet
Number:

1

Date/Time (24 hr clock)	Signature*
4/2/16 1615	
Urgent admission from time day 17055 Under Section 51 Criminal Procedure Act Assessment order	
PC "can't take it anymore" "no a grass didn't tell anybody because they told me they would kill anyone I told like @ Campbell" "are you waking for then?" "well you be safe if I tell you?"	
HRC Voices have gone on for years - worried if told anyone there since death of Mum when he was Age 7 "have to nod and pretend I'm okay" have got worse as years have gone. Now can't cope with them any more. Voices are everywhere "a lot of them" - unsure if men or women 2nd + 3rd person. command at times "started off as my pal" "not any more"	

CHI no
 First name Andrew DOB 2/10/1967
 Last name Shaw Sex: ☐ M ☐ F
 Address 2/10/1967

 or attach addressograph label here

**Nursing, AHP and Psychological
 Therapy Notes**

Sheet Number: 2

Instructions for use:

- Please use these notes sheets continuously, writing in chronological order and ensuring that the date, time (24 hour clock) signature and designation are detailed for all staff involved in the care of the patient. If separate professional notes are held elsewhere, staff should still write a summary of their contact below.

Date/Time (24 hour clock)	Nursing, Allied Health Professional, Psychological Therapy and Other Professional Notes	Discipline/ Designation
24/2/16	<u>Part 4 History</u> seen by forensic service prior to last appearance as concerns says had treatment by @ Campbell, Hartwood Dykebar Levenvale 22 years ago says was admitted but can't remember where not sure if ever detained before could not remember if admitted after say from says saw other psychiatrists but kidded on everything was fine & can't remember who. no CPN unlike if any other not involved - in part no recent contact with mental health services prior to incarceration	

Does not know what
 his previous diagnosis
 was - from notes? Depression / psychosis
 → Previous attempts at suicide to escape
 voices - tablets, and/or occasional 'rape'



[illegible]

CHI no
 First name Andrew DOB 21.4.1967
 Last name Saw Sex: ☐ M ☐ F
 Address

 or attach addressograph label here

Nursing, AHP and Psychological MEDICAL Therapy Notes

Sheet Number: 3

Instructions for use:

- Please use these notes sheets continuously, writing in chronological order and ensuring that the date, time (24 hour clock) signature and designation are detailed for all staff involved in the care of the patient. If separate professional notes are held elsewhere, staff should still write a summary of their contact below.

Date/Time (24 hour clock)	Nursing, Allied Health Professional, Psychological Therapy and Other Professional Notes	Discipline/ Designation
4/2/16	<u>Drug history</u>	
	Sites Allergic to Penicillin → Doesn't know response.	
Says	Has had risperidone xargartil, Depixol, fluoxetine in past Can't remember if has long, if helped or if experienced side effects.	
	says Gused to kid on st doctors that he was taking meds. then stopped taking then completely	
Says on	No current meds.	
	PHH ○ Asthma ○ Diabetes ○ BP ○ IHD ○ CVA.	
	FT → Says role played away 7 from TI when he was Age 7	
	dad Prostate Cancer/Pain haemorrhage? Andy Age 32.	



Patient name:

CHI number:

Date/Time
(24 hour clock)

Nursing, Allied Health Professional, Psychological Therapy
and Other Professional Notes

Discipline/
Designation

FT

Says

No psych family history
of psychiatric illness includes
mood disorder depression

Personal

Youngest of 4 siblings
3 brothers.

- no contact for a long time
as scared they would be
harmed by wires.

Can't remember where he
was born.

but recalls primary school
in Hamilton.

Put in 'church school'
after this - residential.
6 got take out of
school.

Doesn't recall anything else.

Also stated that he had
been 'hurt' by people 'Drip school'.
but became upset + couldn't
elaborate.

Left school, worked at
Arnold Clark selling cars
6 cars, always cars.
Can't remember after that.

CHI no
 First name Andrew DOB 21/4/1967
 Last name Staw Sex: ☐ M ☐ F
 Address

 or attach addressograph label here

Nursing, AHP and Psychological Therapy Notes

Sheet Number: 4

Instructions for use:

- Please use these notes sheets continuously, writing in chronological order and ensuring that the date, time (24 hour clock) signature and designation are detailed for all staff involved in the care of the patient. If separate professional notes are held elsewhere, staff should still write a summary of their contact below.

Date/Time (24 hour clock)	Nursing, Allied Health Professional, Psychological Therapy and Other Professional Notes	Discipline/ Designation
4/2/16	<u>Social history</u> No fixed abode Doesn't know about grant of Benefits Social worker - not sure if has one. non-smoker	
	<u>Alcohol + Drug history</u> AS HPC some harmful use in context of self-medicating symptoms. Denies daily use, tolerance or past history of dependence including withdrawal symptoms. Says takes cocaine regularly - nasally; can't recall frequency Diazepam - has only taken when prescribed in past. Denies use of solvents/aerosols Denies use of heroin/estanylanphethamine LSD/magic mushrooms	



CHI no
 First name Anna DOB 21/4/1967
 Last name Gray Sex: ☐ M ☐ F
 Address

or attach addressograph label here

Nursing, AHP and Psychological MEDICAL NOTES Therapy Notes

Sheet Number: 5

Instructions for use:

- Please use these notes sheets continuously, writing in chronological order and ensuring that the date, time (24 hour clock) signature and designation are detailed for all staff involved in the care of the patient. If separate professional notes are held elsewhere, staff should still write a summary of their contact below.

Date/Time (24 hour clock)	Nursing, Allied Health Professional, Psychological Therapy and Other Professional Notes	Discipline/ Designation
4/2/16	pre-norbid Personality dikes, dacks at fields / landscapes. quiet person; private person. no strong religious beliefs No specific hobbies or Interests. <u>THE</u> well kept, obese, gray hair intermittent eye contact good rapport psychomotor activity 2 stereotypic movements. rubbing thumbs together repetitive complex hand movements. orofacial movements - non tongue to each side of mouth intermittently Speech (i) rate. slow - long pauses at times hesitant.	piano player



Patient name:

CHI number:

Date/Time (24 hour clock)	Nursing, Allied Health Professional, Psychological Therapy and Other Professional Notes	Discipline/ Designation
	Volume 5.	
	Quantity - only answering questions initially improved to some prompts & encouragement.	
	mood 5) & related mood.	
	② Perceptive disturbed in context of psychotic symptoms - feel better the voice not present effect reactive, visibly frightened & anxious.	
	Thought : as per HPC FID - Thought Blocking. Difficulty processing / answering questions evident during ILU.	
	Delusional - persecutory passivity.	
	Harm → No current thoughts or plans to harm himself or thoughts of suicide. No thoughts of harm to others.	
	Perception auditory hallucinations 2 nd 3 rd person ~~Not interested~~ as 'everywhere'.	
	Comrad Constantly there.	
	Cognition poor attention + concentration.	
	Not orientated to time or place - Monday, Year X Did not know what Month X Year X	
	Knows Name DOB Can't remember age. Unaware of any news / world events.	

CHI no
 First name Andrew DOB 21/4/1967
 Last name Shaw Sex: ☐ M ☐ F
 Address

or attach addressograph label here

Nursing, AHP and Psychological Therapy Notes

Sheet Number: 6

Instructions for use:

- Please use these notes sheets continuously, writing in chronological order and ensuring that the date, time (24 hour clock) signature and designation are detailed for all staff involved in the care of the patient. If separate professional notes are held elsewhere, staff should still write a summary of their contact below.

Date/Time (24 hour clock)	Nursing, Allied Health Professional, Psychological Therapy and Other Professional Notes	Discipline/ Designation
4/2/16	MP / Summary (45) 2 psychotic symptoms. - thought disorder, delusional system, auditory hallucinations. History of cocaine / Alcohol history. Previous history of inpatient treatment + forensic history of automobile offence. History of attempts at harming himself - overdose, "using rope" - states to try to escape voices (states now voices told him if did manage to harm himself that they would still get me) - no current thoughts or plan. No thoughts of harm to others. ? Schizophrenia form illness need to exclude drug induced psychosis or delirium (less likely no physical health complaints)	



Patient name:

CHI number:

Date/Time (24 hour clock)	Nursing, Allied Health Professional, Psychological Therapy and Other Professional Notes	Discipline/ Designation
	RA ① Detained under S2D Assessment order CP Act	
	② ① Dry Kordex - prescribe PRN clonazepam for anxiety. Clonazepam can be given water. If utilized patient cannot provide informed consent	
	③ Physical Blood Tamarcan LFTS, LFTS, glucose, Lipids Bone Profile, TFS, CRP ESR, FBC.	
	④ General obs. → to be of if any carens voice thoughts of self harm	
	⑤ Ask an team to Rlu re T3 tomorrow.	
	④ ① Dry test urine for illicit substance.	
	⑤ RSSU. SIE off Backpain, nil else Physical: are weyft Justice Anaemia. Pupils equal to accommodation No per touch available CN II - XII intact Power 5LS ① tone Reflexes ② PRTS ③ normal Co-ordination. ① gait.	

CHI no

First name

DOB

Last name

Sex: ☐ M ☐ F

Address

or attach addressograph label here

**Nursing, AHP and Psychological
Therapy Notes**NURSICAL
NOTES

Sheet Number: 7

Instructions for use:

- Please use these notes sheets continuously, writing in chronological order and ensuring that the date, time (24 hour clock) signature and designation are detailed for all staff involved in the care of the patient. If separate professional notes are held elsewhere, staff should still write a summary of their contact below.

Date/Time (24 hour clock)	Nursing, Allied Health Professional, Psychological Therapy and Other Professional Notes	Discipline/ Designation
	Temp 36.6	
	Pulse 100bpm good volume	
	BP 148/87	
	JVP	
	OK	
	HS I+II + O	
	Apex @ posita	
	Peripheral pulses @	
	Resp rate 14/min	96% O ₂
	BS vesicular	Saturated
	Good Air Entry	
	Percussion resonant	
	Abdomen	
	Soft	
	slight epigastric	
	tenderness on deep	
	palpation	
	OL OK OK OS	
	BS @	
	hemigastrocystitis not	Examined
	PR not required	
	Per	
	Ask GP to repeat at next	
	visit	



⑥ - 206

⑦ need dcl psychiatry
withLd
BRAD
SECTION
DOCT 10
PSC

[illegible]

8/2/15 @ 16h30

Andrew was quite distressed and reluctant to speak to me in much detail at first. He was unable to report the events which led to his arrest, but did say that he was in a holding cell. It took a considerable amount of time for him to settle before he was able to engage relatively freely. He complained about hearing voices "all the time" since the age of 8 years. He reported that, 20 years ago, the voices had killed Dr Campbell because he had told her too much. He muttered tearfully that he sometimes lands up in places without knowing how he got there. He said that the voices tell him that others want to harm him; that they are the only ones who care about him; that others want to take him away from them. He said that he feels compelled to listen to the voices. He believes that they implanted a device in his brain 20 years ago.

He reported that the voices instruct him to harm himself and others. In the past he has attempted suicide in response to the voices. These attempts included ODs and an attempted hanging many years ago. He took the ODs but didn't go through with the hanging but called the ambulance instead.

He said that the voices have been present for the past 20 years and that nothing has really worked. He reported that he has been on chlorpromazine, risperidone depot and depixol depot; but also that he has only been compliant with medication for 3 years when not in hospital.

He reported that he uses illicit drugs to try and block the voices. Previous to his admission he was using cocaine 3 to 4 times per week, as well as valium but does not believe that the valium was effective.

He said that he has been admitted to hospital on 3 occasions in the past and that his longest admission was 8 months and many years ago.

MSE

Andrew presented as a short man, overweight. Self care was reasonable. Andrew was extremely agitated with hand wringing. He was flushed and tearful and eye contact was almost non-existent. He seemed distracted and reported that he was experiencing voices; but there was no obviously objective evidence of psychosis. At times he seemed unable to contain himself and that he could be unpredictable; however I did not feel threatened. He took a considerable period before he settled down. He gave a poor account of himself.

Affect was restricted and mood congruent. He was depressed and had thoughts about not waking up to escape the voices, but no intentions to kill himself. [He also reported that the voices had told him that they would go with him wherever he went]. His concentration was poor. Weight and appetite was fine.

He was not thought disordered. His replies to questions were however vague at times but this seemed to be due to his extreme preoccupation with his voices and his reluctance to engage. He was unable to report the events leading to his arrest and hospitalisation. Voices were multiple and command type instructing him to harm himself and others. He said that has never hurt others in response to the voices and had no self harm or suicide thoughts. He had paranoid beliefs that a chip had been inserted in his brain and had others would come to harm as result of the voices if he said too much. Insight and judgement was impaired.

Andrew was willing to accept a new medication. We discussed sulpiride and he agreed to take this after I explained what the indications were.

His account of the voices and paranoid beliefs appears to be truly held by him.

Plan

- commence sulpiride 200mg bd
- get collateral from landlady
- ECG and bloods
- Sign consent form



Jonathan

9/2/16

Andrew commenced the interview by saying that did not want them anymore. This was in reference to his voices. He was also worried about the treatment and asked if it would harm him. I told him about the media reports on Dr Campbell which showed her to be still alive. Later during the interview, he anguished about this and asked how the voices could have lied to him for 20 years. He asked whether I had spoken to her.

He was born in Bellshill and raised in Hamilton by his parents. He had 3 older brothers who were 15, 17 and 18 years older than him. He reported good relationships with all except with brother Duncan (15 years older) who he said sexually and physically abused him. He did not want to give any details. He said that his father drank a lot and was abusive to his mother but that he was "not a bad man" and that they had a happy marriage.

His mother was a cleaner and his father worked in the steelworks. He was very close to his mother. She died at the age of 45 years when he was 8. He said that no one looked after him after this. At the age of 12 years, he was placed in Geilsland list D school. He denied any abuse but felt scared because he believed they were trying to program him. He said that they did activities and received no schooling. This is where he learned to drive cars as they lived on a big estate and he used to cut the grass with the tractor. He said that driving took the voices away.

He stole his brother's car at the age of 13 years and smashed it. This was in retaliation for the abuse. He stole another car at age 16 and was sent to a borstal YOI for a year. He returned to live with his father for a year before he returned to prison after another motor vehicle theft.

He said that he has been sentenced to prison about 20 times for car theft. He said that the voices couldn't get into cars. He later said that the last time he stole a car was 20 years ago. He said that since the age of 20 years, he had been mostly in prison, than out of prison and that the longest time he spent out of prison was currently, which stood at 14 months. He said that whilst in prison he would report that he was well, despite ongoing symptoms, because he thought that the doctor would be killed, as Dr Campbell had been.

He has sold second hand cars in the past, fixing and then selling it.

He has been in a relationship with Moira Duggan for the past 35 years but has never lived with her. They have a 28 year daughter Kelly Ann who has 2 children. He has little contact with his daughter. He last saw Moira 7 weeks ago.

MSE

Andrew presented as agitated, nervous and tearful. He seemed distracted and did not make eye contact but always looking around at his surroundings. He may have been distracted by voices. Affect was restricted and mood congruent. It was difficult to follow his conversation at times when he spoke in cryptic phrases but it was possible to get his meaning with repeated questions. He referred to police as the "Police soldiers" and believed that they acted at the behest of his voices. He reported delusions of reference from the telly and radio and believed that his thoughts could be read and altered. He reported numerous paranoid delusions and he continued to report auditory hallucinations in the 2nd and 3rd person.

I spoke to Carol Anne, Andrews landlady (07736-317119). She said that she first met him about 8 months ago when he signed the tenancy for his flat and that she did not have much contact with him till in December when he began making contact with her. She reported that he appeared to be "on the go" all the time. He would text her at odd times and during the night. He frequently did not make sense when he spoke to her. He would jump from topic to topic. He seemed preoccupied. She was concerned about the company he kept and felt that he was being exploited and harassed by a young associate of his who demanded money, cars and other properties from Andrew. She saw him as a sad and lonely figure with no friends. She said that she never felt threatened by Andrew and she never felt that his life was at risk. She believed that he restored and sold second hand cars; she advertised cars for him on a few occasions. It is unclear to her how he came to the attention of Police.

9/2/16 

NHS Lanarkshire Mental Health Services
Generic Integrated Care Pathway (Inpatient)

Outcomes Plan

Plan
number:

Lead Professional:
(e.g. CPN, named nurse, doctor etc.)
Date plan started:
Date plan ended:
(to be reviewed at least yearly)
Reason plan ended:

CHI 2104673933
Shaw, Andrew
DOB: 21/04/1967 Male
No Fixed Abode
NF1 1AB
PIMS P1518904

To be completed by members of the Multidisciplinary Team as appropriate

Identified Need (consider strengths, past experiences and aspirations)	Expected Outcome/ Rationale	Intervention and Resources Required – services, professionals, equipment, etc. (include patient and professionals' responsibilities)	Start date	Review/end date, reason ended	Actioned by (signature/date)

Patient name:		CHI/PIMS number:			
Identified Need (consider strengths, past experiences and aspirations)	Expected Outcome/ Rationale	Intervention and Resources Required – services, professionals, equipment, etc. (include patient and professionals' responsibilities)	Start date	Review/end date/reason ended	Actioned by (signature/date)
Outcome Plan agreed by: Lead Professional (e.g. CPN, named nurse, doctor), patient and informal/formal carer ☐ Yes ☐ No Lead Professional and patient ☐ Yes ☐ No Lead Professional only ☐ Yes ☐ No If patient not involved, please state reason:					
Has the patient been given verbal/written advice as to who is the single point of contact for co-ordinating the delivery of care and support? If no, reason: Does the patient feel satisfied with their involvement in the design of their care? If no, reason: Has the informal/formal carer been given verbal/written advice as to who is the single point of contact for co-ordinating the delivery of care and support? If no, reason: Does the carer feel satisfied with their involvement in the design of this care? If no, reason:					
Advocacy involvement required? Yes ☐ No ☐					
Completed by: (PRINT NAME)		Signature:		Designation:	
				Date:	

CHI 2104673933

Shaw, Andrew

DOB: 21/04/1967 Male

No Fixed Abode

NF1 1AB

PIMS P1518904

Sheet
number:

Multidisciplinary Team (MDT) Review Meeting Details

NHS Lanarkshire Mental Health Services
Generic Integrated Care Pathway (Inpatient)

To be completed by members of the Multidisciplinary Team as appropriate. Record meeting discussions/outcomes on MDT Progress Notes

Date/ Time	People Present (Prompt: are relevant others aware, e.g. family, AHPs, etc.)	Goal and Outcome for Leave	Patient Feedback (including use of diaries if applicable)	Public Protection Issues? (If yes refer to Legislation Section) Yes ☐ No ☐	Estimated Date of Discharge?	Signature/ Designation
				Yes ☐ No ☐		
				Yes ☐ No ☐		

Patient name:	CHI/PIMS number:
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To be completed by members of the Multidisciplinary Team as appropriate. Record meeting discussions/outcomes on MDT Progress Notes

Date/ Time	People Present (Prompt: are relevant others aware, e.g. family, AHPs, etc.)	Goal and Outcome for Leave	Patient Feedback (including use of diaries if applicable)	Public Protection Issues? (If yes refer to Legislation Section) Yes ☐ No ☐	Estimated Date of Discharge?	Signature/ Designation
				Yes ☐ No ☐		
				Yes ☐ No ☐		

NHS Lanarkshire Mental Health Services
Generic Integrated Care Pathway
Multidisciplinary Team (MDT)
Review Meeting Summary

**Review
number:**

CHI 2104673933

Shaw, Andrew
DOB: 21/04/1967 Male
No Fixed Abode

NF1 1AB
PiMS P1518904

Instructions for use:

- To be completed for all reviews by members of the Multidisciplinary Team as appropriate.

Patient's Views

Was the patient involved in the review process? Yes ☐ No ☐

If yes, method of input: ☐ phone ☐ face to face ☐ letter ☐ proxy

Views expressed:

If not involved please give reason:

Does the patient feel their needs are being addressed/met though the current Outcomes Plan? Yes ☐ No ☐

If no, reason:

Does the patient feel safe? Yes ☐ No ☐

If no, reason/detail: ☐ family ☐ community ☐ services, peers ☐ services, staff

Does the patient feel satisfaction with involvement? Yes ☐ No ☐

If no, reason:

 **Was the use of MyRAP or other Recovery Plan discussed?** Yes ☐ No ☐

If yes, outcome:

 **Was the patient advised regarding an Advance Statement?** Yes ☐ No ☐

If yes, outcome:

Not applicable ☐

Is the patient satisfied with the opportunities available for social interaction? Yes ☐ No ☐

If no, give details:

Informal/Formal Carer(s) Views (including young carers)

Was the carer involved in the review process? Yes ☐ No ☐

If yes, method of input: ☐ phone ☐ face to face ☐ letter ☐ proxy

Views expressed:

If not involved please give reason:

Does the carer feel the needs of the patient are being addressed/met though the current Outcomes Plan? Yes ☐ No ☐

If no, reason:

Patient name:	PIMS/CHI number:
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Informal/Formal Carer(s) Views (continued)	
Does the carer feel satisfaction with their involvement in the design of the patient's care? If no, reason:	Yes ☐ No ☐
Does the carer feel able to continue their caring role? If no, reason:	Yes ☐ No ☐
Has the carer been offered an assessment? If no, reason:	Yes ☐ No ☐ Not applicable ☐
Additional arrangements for young carers – has a referral been made to children's services assessment/support? If no, reason:	Yes ☐ No ☐ Not applicable ☐

Contributors Views
Were all contributors involved in the review process? Contributors views:
If not involved please give reason:

Summary of Review/Decisions and Actions Taken/Amendments to Outcomes Plan

Next Review Meeting	
Date of next review: (no more than 1 year from date Outcome Plan agreed) Time: Venue: Next meeting agreed with patient and carer? Yes ☐ No ☐ Patient informed of single point of contact? Yes ☐ No ☐ If no, provide reasons: Carer informed of single point of contact? Yes ☐ No ☐ If no, provide reasons:	Attendees:

Completed by:	Signature:	Date:
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Shaw, Andrew
 DOB: 21/04/1967 Male
 No Fixed Abode

NHS Lanarkshire Mental Health Services
 Generic Integrated Care Pathway

NF1 1AB
 PIMS P1518904

Inter Hospital Transfer of Care

To be completed for inter hospital transfer only

	Signature	Date/Time (24 hr clock)
Date transfer date was set: / / <i>(Clinical Readiness Date – applicable to Old Age Psychiatry)</i>		
Date of Pre-Transfer meeting: / /		
CPN/Supports contacted for MDT		
Date of Transfer: / /		

Transfer Checklist	Yes No N/A	Signature	Date/Time (24hr clock)
Patient/Relative/Carer/Named Person informed of transfer date	☐ ☐		
Ward transfer procedure completed	☐ ☐		
TX2 Form completed for all detained patients	☐ ☐ ☐		
If patient detained under the Mental Health Act, Suspension of Detention Form completed for patients going into non-mental health wards <i>(transferring care and treatment to other ward/hospital) *</i>	☐ ☐ ☐		
Transport organised for patient/escort	☐ ☐		
Patient's core documentation (ICP folder and case notes – copies if appropriate) and medication prescription form transferred with patient	☐ ☐		
Local Patient Satisfaction Questionnaire: ☐ given ☐ posted			
MUST Nutritional Assessment Score recorded on transfer	☐ ☐		
Medication ordered	☐ ☐ ☐		
Medication transferred with patient	☐ ☐ ☐		
Possessions/valuables/clothing book completed/items returned	☐ ☐		
Other Services informed of Discharge:			
• Community Psychiatric Nursing Service	☐ ☐ ☐		
• Dietetics	☐ ☐ ☐		
• GP	☐ ☐ ☐		
• Home Support Services	☐ ☐ ☐		
• Homeless Team	☐ ☐ ☐		
• Occupational Therapy	☐ ☐ ☐		
• Psychiatry	☐ ☐ ☐		
• Psychology	☐ ☐ ☐		
• Spiritual and Religious Care	☐ ☐ ☐		
• Social Work	☐ ☐ ☐		
• Other: (specify)			

*1. Patient detained under Emergency Detention Certificate (Chapter 7, sect 91, page 209, MHC&TSA 2003) – due to brevity of period of emergency detention, few occasions this would be required.

2. Patients detained under a Short Term Detention (Chapter 2, sect 103, page 52) – a suspension certificate would not have to be granted as no hospital is specified.

3. Patient detained under a CTO or ICTO (Chapter 4, sect 49, page 113) – would be permissible to grant a suspension certificate. RMO must cite residence in second hospital as condition of the suspension certificate in order to remain detained.

Link to forms: http://www.scotland.gov.uk/Topics/Health/health/mental_health/mhla/mha_Forms

[illegible]

Verbal Reporting	Escorting Nurse (signature)	Receiving Nurse (signature)
The current observation and legal status of the patient has been verbally reported as: Observation Status: ☐ General ☐ Constant ☐ Special Legal Status: <i>(please state)</i>		

CHI 2104673933

Shaw, Andrew

DOB: 21/04/1967 Male

No Fixed Abode

NHS Lanarkshire Mental Health Services
Generic Integrated Care Pathway**Continuity of Care/Discharge Summary**

NF1 1AB

PiMS P1518904

Person's preferred name: _____

Phone number: _____

 **Advance Statement made?** ☐ Yes ☐ No

If yes, date recorded: _____

Legal Status: _____

Review date: _____

Lead Professional:

Address: _____

Telephone number: _____

Named Person:

Address: _____

Telephone number: _____

People Involved in Care/Interventions

Name	Roles and Responsibilities	Address	Contact No.

Aims of Admission	Met	Unmet	Comment	Lead Person
	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		

Medication on Discharge	8am	1pm	6pm	10pm	Medication on Discharge	8am	1pm	6pm	10pm

Staying Well Plan**Actioned by:***(include patient responsibilities)*

Patient name:	PIMS/CHI number:
----------------------	-------------------------

Relapse Management Plan <i>(this includes missed appointments or changes to planned interventions)</i>	
List any relapse indicators that would require immediate action or response:	What would be the response:

Known Risk Indicators <i>(tick those that apply or state others)</i>	
☐ Risk to self: self harm, alcohol, drugs, self neglect, absconding, etc. ☐ Risk to others: violence, specific threat directed towards an identified individual or non-specific risk ☐ Environmental: one person visit or two, seen at clinic or public place	Other: (specify)

Risk Management Plan	
Identify the action that should be taken:	By whom:

Action to be taken in the event that the relative/carer is no longer able to provide care:

Action to be taken in the event of unplanned absence of the Lead Professional:

The person who has agreed to provide care in the absence of the Lead Professional:	
Name:	Telephone number:

Patient or Carer Comments:

Discharge Summary completed by: (PRINT NAME)	Patient's Signature:
Signature:	Date:

 ¹⁵ Continuity of Care/Discharge Summary Copies To:	
Patient: ☐ accepted ☐ declined ☐ Carer (with patient agreement) ☐ Community Team ☐ Consultant ☐ Designated MHO ☐ GP	☐ Independent Advocate ☐ Lead Professional ☐ Named Person ☐ Social Services ☐ Other: (specify)

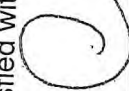
For general information and advice on mental health matters contact: NHS24 on 08454 24 24 24 and Elament website on www.lanarkshirementalhealth.org.uk

Patient name: Andrew Shaw (or attach label) PIMS/CHI number: 2104673933	NHS Lanarkshire Mental Health Services Generic Integrated Care Pathway (Inpatient) BECKFORD LODGE IONA WARD LOW SECURE Outcomes/Care Plan	Lead Professional: Stacy Stewart (e.g. CPN, named nurse, doctor etc.) Date plan started: 6/2/16 Date plan ended: (to be reviewed at least yearly) Reason plan ended:
Sheet number: <u>1</u>		

To be used by members of the multidisciplinary team as required

Identified Need (consider strengths, past experiences and aspirations)	Expected Outcome/Rationale	Intervention and Resources Required – services, professionals, equipment, etc. (include patient and professionals' responsibilities)	Start date	Review/end date, reason ended	Actioned by (signature/date)
Andrew is a 47 year old male transferred from Low moss prison under an assessment order(52d). He has a long extensive history with both general adult and Forensic Psychiatric services. Was in jail for non-payment of fines(Traffic offences) numerous incidents of traffic offences non- payment of fines and one incident previously of pouring hot soup over a former partner. He is currently experiencing auditory hallucinations and delusional ideation of a paranoid nature. For example states that people have placed a chip inside his brain and the same people also tamper and put things inside his mediation..	Complete full psychiatric assessment of need. Identify appropriate treatment and diagnosis. Person centred individualised care plan which addresses all his needs	1:1 interventions to continue to maintain therapeutic relationship and monitor response to medication, nursing interventions and allied health professionals. Observe for any progress/deficit and document any changes within nursing notes report back at MDT. Review Care plan on a regular basis and change as per clinical need. - Encourage Andrew to participate in all aspects of his care to increase client self determination. - Continue to carry out and update risk assessment HCR 20.AVON, TRAFFIC LIGHTS through changes in clinical need and regular risk review meetings. - Encourage Andrew to take part in all group activities and ask him about any interests hobbies he has and where possible incorporate this into his day to day living to gain a structure to the day to sustain recovery and maintain good mental health - Carry out procedural security checks to ensure the safety of Andrew and others whilst he is still an inpatient. For example D.O.A screening, searches, room checks. Res 1 protocols see separate care plan regarding RES1. Explain to Andrew the importance of these procedures and how they will assist in helping him with his recovery. - Continue to discuss thoughts and feeling re mood on a regular basis. Monitor for any changes in mood and	6/2/16		 5/2/16

			utilise assessment tools to gain more accurate baseline. 7. Discuss with Andrew coping strategies which will enable him to sustain mental well being 8. Physical health checks to promote a healthy lifestyle. Carry out Waterlow, MUST, Educate Andrew about healthy diet and exercise and encourage him to make choice of a healthier lifestyle through appropriate groups and specialist allied health professionals who can deliver such interventions. 9. The overall aim of this care plan is to develop an holistic person centred, individualised treatment which meets Andrews holistic needs.			 5/2/16	

Patient name: <u>Andrew SHAW</u>		PIMS/CHI number: <u>2104673937</u>			
Identified Need (consider strengths, past experiences and aspirations)	Expected Outcome/ Rationale	Intervention and Resources Required – services, professionals, equipment, etc. (include patient and professionals' responsibilities)	Start date	Review/end date/reason ended	Actioned by (signature/date)
Outcome Plan agreed by: ☐ Lead Professional (e.g. CPN, named nurse, doctor), patient and informal/formal carer ☐ Lead Professional and patient ☐ Lead Professional only If patient not involved, please state reason:					
Advocacy involvement required? ☐ Yes ☐ No					
Has the patient been given verbal/written advice as to who is the single point of contact for co-ordinating the delivery of care and support? If no, reason: Does the patient feel satisfied with their involvement in the design of their care? If no, reason: Has the informal/formal carer been given verbal/written advice as to who is the single point of contact for co-ordinating the delivery of care and support? If no, reason: Does the carer feel satisfied with their involvement in the design of this care? If no, reason:					
Patient signature:  Date: <u>7/2/16</u>					Yes ☐ No ☐ N/A ☐
Completed by: (PRINT NAME) JIM PARK			Signature:  Designation: RMN		Date: 6/12/16

NHS Lanarkshire Mental Health Services
Generic Integrated Care Pathway (Inpatient)
Multidisciplinary Team (MDT)
Progress Notes

Shaw, Andrew
DOB: 21/04/1967 Male
No Fixed Abode

NF1 1AB
PIMS P1518904

Instructions for use:

- Please use these notes sheets continuously, writing in chronological order, and ensuring that the date, time (24 hour clock) and details of all MDT meetings regarding the patient are documented.
- As this is a legal document, please ensure that the person who minutes the meeting signs and clearly prints their name.

**Sheet
Number:**

Date/Time (24 hr clock)	Progress Notes
8.2.16	Dr Jonathan L Cameron (Psychologist) S/N K Durcan OT K Jameson, Scn C Watson, Andy (Patient). • Andy states he was arrested 4 weeks ago in Glasgow. States he was not prescribed medication prior to his arrest. Last psychiatric hospital admission was 8 years ago to Loretto Hospital. • States he has been hearing voices for 30 years and these are no different at present. Andy states voices tell him not to say anything. • States he last used drugs a month ago (cocaine). • Andy made reference to a "chip" he believes is in his head which causes him distress. States voices tell him not to take medication. • Lindsay suggested to Andy that some people find benefit in Psychological therapies as he has not been keen to accept medication in the past. • Andy gave permission for Dr Jonathan to speak to his landlady who obviously knows him well. States he "doesn't know" if it is ok for Dr to speak to his daughter. • Continue to assess mental state, general behaviour, emotional state and personality issues. • Dr Jonathan will see patient on 1:1 basis. C Watson Scn.

Patient name: Andrew Shaw

PIMS/CHI number: 2104673933

Multidisciplinary Team (MDT) Progress Notes

Date/Time
(24 hr clock)

Progress Notes

15/2/16

Dr Johnathan, L Cameron (psychologist)
S/N Stacy Stewart, Andy (Patient)

- Andy states he has "not being to good the past couple of days".
- States he had been having bad dreams.
- States he feels restless
- Dr Johnathan advised medication could take a few weeks to work.
- Andy stated he came out the doctors and the police arrested him and told him he was going too fast through a red light.
- Dr Johnathan questioned Andy on how many properties he owned, Andy range on this answer, stating "no can own anything" and he has "had stuff and people have took it off him before".
- Andy became very vocal shouting that everyone was trying to take everything off him because they think he's "bonkers", he states gangsters gure him 26 text a day and he's told us he is not a "grass".
- He states he has 30 cars, 10 private number plates and people are taking things off him.
- States he's happy being "lonely" and he only cares about his "mum, dad, daughter, Dr Campbell and partner".
- Increase sulphuride 200mg x 3 daily

22-2-16

Dr Jonathan, S/N Watson, S/N S. Stewart
L. Cameron (Psychologist), K. Jamieson (OT), Andrew (Patient)

- A.M. Cairne has some concern about a young woman Andrew stated was his "daughter". This girl is not his daughter and Adult Support and Protection being discussed as she has learning difficulties.
- Andrew's presentation changes reported to Dr Jonathan. His presentation changes when his is aware of staff's

CHI no 210467-3933
 First name Andrew DOB 21.04.67
 Last name Shaw Sex: ☒ M ☐ F
 Address C/O Lana ward

 or attach addressograph label here

Multidisciplinary Team (MDT) Meeting Notes

Sheet Number:

Instructions for use:

- Please use these notes sheets continuously, writing in chronological order and ensuring that the date, time (24 hour clock) signature and designation are detailed for all staff involved in the care of the patient. Please record all details of MDT meetings, ensuring that the person who minutes the meetings signs and clearly prints their name.

Date/Time (24 hour clock)	Progress/MDT Meeting Notes	Discipline/ Designation
	observations - Mental distress and bizarre eye movements are not evident during unobtrusive observation. However when in staff's presence he appears to be responding to non-evident stimuli. - Andrew reports his week to be "not good". States voices say bad things to him "all the time" and "they say medication is poisoned". He spoke about medication making no difference to his symptoms and referred to the "chip" in his brain. - Andrew agrees he usually discontinues any prescribed anti-psychotic medication. He agrees to accept depot injection. - States he has been prescribed Chlorpromazine, Risperidone and Risperidone in the past. - Asked to discuss index offence. States he came out of his house and Police tried to stop him in his car. He states he tried to get away from them. Tearful during conversation. Dr Jonathan will speak to Andrew later on 1:1 meeting. - Andrew's behaviour following index offence was very organised. He was attempting to evade capture by telling untruths to others. - Assessment for next week to	
		Autts sc.



Date/Time (24 hour clock)	MDT Meeting Notes	Signature/ Designation
	conclude whether Andrew is fit to plead at court.	Andrew ^{SW}
	• Prescribed oral Risperidol and depot Risperidol Consta to be given on Friday 26/02/16.	
29/02/16	Dr Jonathan, Sca Watson, S/N. S. Stewart, K. Tammison (OT), A.M. Gaine (MHO), Andrew (Patient), Clare (MHO student).	
	• Andrew has been phoning Ann Marie asking her to collect clothes for him despite his "landlady" being able to do this.	
	• Speaking superficially to MHO Ann Marie about voices and spaceships. She feels he is not entirely genuine. Person Andrew states is his daughter is not his daughter. Ann Marie feels Andrew's presentation is "an act".	
	• Dr Jonathan is in agreement with multi-professional team that Andrew could return to prison and is fit to plead to the charges.	
	• Andrew denies upsetting gentlemen who have complained Andrew was rude to him during telephone call.	
	• Dr Jonathan explained purpose of admission was for assessment and advised he should continue with medication if he returns to prison. Dr Jonathan feels Andrew's crime was influenced by his mental state at the time but is now well enough to understand and plead charges.	
	• Ann Marie explained situation with lady Andrew stated was his daughter. This lady	

Multidisciplinary Team (MDT) Meeting Notes

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[illegible]

CHI number:**Signature/
Designation**

CHI 2104673933

Shaw, Andrew

DOB: 21/04/1967 Male

No Fixed Abode

Nursing, AHP and Psychological
Therapy Notes

Sheet Number: 1

Instructions for use:

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Date/Time (24 hour clock)	Nursing, Allied Health Professional, Psychological Therapy and Other Professional Notes	Discipline/ Designation
04/02/16 1430	Andrew Shaw, a 49 year old man, has been transferred from Low Moss Prison at 1345 today. Andrew has been transferred to IONIA Ward under an assessment order (S20). Andrew has presented with psychotic symptoms and during interaction with staff, on arrival, Andrew voiced that he believed people were after him. He also disclosed that he currently experiences auditory hallucinations, however, he did not expand on same. Instead advised staff that he was worried they may be harmed if he 'gussed'. Andrew also voiced that 'the people' have placed a 'chip' within his brain and that these same people also tamper and 'put things in' medication. On several occasions Andrew questioned whether it was 'ok' to drink his tea and also asked if there was 'anything in it'. Reassurances given to Andrew regarding same and he was able to drink his tea. During interaction Andrew spoke about 'Dr. Campbell' on several occasions and voiced that he believed she had been 'killed'. He believed that this was a result of Andrew disclosing to her in the past that he was experiencing auditory hallucinations. During interaction there were periods when Andrew was able to advise staff of where he lived and that he would like some snacks from the shops. Andrew became fearful during interaction and appeared agitated, at times he appeared hyper-vigilant and when the ward fire alarm was tested Andrew appeared distressed and asked	



Patient name: Andrew Shaw

CHI number: 2106673933.

Date/Time (24 hour clock)	Nursing, Allied Health Professional, Psychological Therapy and Other Professional Notes	Discipline/ Designation
	Current author 'is that the alarm to let them know I am here?' Andrew would not elaborate on 'them' however, he accepted all reassurances. Andrew has been notified of who he can approach for support and is also aware of who the Senior charge nurse is (C. Watson) and Primary Nurse (S. Jordan). Andrew has been orientated to his sideroom within JONA ward however, he did not wish to be orientated to the rest of the ward at present. On admission Andrew had £122.30, 2 mobile phones, a wallet, keys and a bank card however, no clothing. Staff will ensure Andrew has the opportunity to have access to clean clothing.	
20.11.16	Andrew remained in his sideroom, most of duty. Mueser and Waterlow Assessment Charts completed. Scored 3 and 0 respectively. Initial Risk Assessment completed, to be signed by Dr Critch. Seen by Dr Bradley, who completed admission process. Prescribed Lorazepam 1mg orally and 2mg i.v. PRN as per handbook. Bloods to be taken tomorrow. Placed on general observation. DOR urine sample, routine urinalysis and MSSU to be obtained. Staff tenderness noted in abdomen. GP to check when next in ward. All case notes to be checked up. During interview Andy said he has recalled, risperidone, lergasetyl, depured and Fluoxetine in the past. He admitted to taking cocaine recently, but can't recall frequency. Denies using other substances. Has previous history of dealings with mental health services, has been treated in Hartwood, Dykebar and Laverdale. Andy denies any thoughts of self harm or feelings of aggression towards anyone. Some paranoid ideation present, asking if "they	Sign.

CHI no 2104673933
 First name ANDREW DOB 21.04.67
 Last name SMITH Sex: ☒ M ☐ F
 Address NO 1200 ABOOD
 or attach addressograph label here

Nursing, AHP and Psychological Therapy Notes

Sheet Number:

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	were coming to get him " on a few occasions. didn't elaborate on who "they" were. When asked about family involvement he said he didn't want that because they may become endangered if they do. Andy didn't want Advocacy involvement. He appeared to be reacting to external stimuli. during admission process, Worry at times and constantly rubbing his hands. Appeared anxious during process. T4 form completed but left unsigned. I dated because can only be dated when medication is given.	P. Lg P. Lg
5/2/16 0640	Andrew in side room at commencement of duty. Staff introduced themselves and offered Andrew some supper in dining room which he declined due the other patients being there. He did however accept a cup of tea in his room. Staff offered Andrew the opportunity to discuss any concerns or ask any questions however did not disclose same at this time. Minimal eye contact offered during interaction. Andrew encouraged to seek staff support at any time during the night. Gained sleep around 2300hrs and appears to have slept well over night.	



Patient name: ANDREW SHAWCHI number: 2106673933

Date/Time (24 hour clock)	Nursing, Allied Health Professional, Psychological Therapy and Other Professional Notes	Discipline/ Designation
5.2.16 1100	NOTED TO DR EXPLAINING SOME SEVERAL ANXIETY OFFERS FOR MEDICATION INITIALLY SUSPICIOUS/SADLY BUT ACCEPTING OF LMS LOXAPANE IN TABLET FORM AT 0940 HOURS WITH SIGNIFICANT TACHYCARDIA. MORE SPONTANEOUS, EMPLOYMENT IN STRAIN, EYE CONTACT, REACTIVE. FBC OBTAINED AM SUFFERING D.O.A. SUE TO LOSS. MORE SAD AT TIME OF WRITING.	5Pw
1252	LOW PROFILE MAINTAINED ON THE WARD. ACCEPTED LUNCH WITH NO PROBLEMS. QUIET AND UNUSUAL AT THIS TIME. ONE TO ONE TO BE CARED ON IN THE PM. RAISING NO CONCERNS AT THIS TIME.	ALGd.
1740	ANDREW WAS VISITED BY HIS FRIEND AND LANDLORD WHOM HE HAD CALLED LAST NIGHT AND ADVISED OF ADMISSION. ANTHONY OBSERVED VISITED, AND ANDREW WAS APPROPRIATE THROUGHOUT. VISITOR ASKED WHY HE WAS RESTLESS ON CHAIR AND LOOKING FROM SIDE TO SIDE, SHE ENQUIRED IF THIS WAS A RESULT OF MEDICATION AND ANDREW EXPLAINED IN A CALM MANNER THAT THIS IS A SYMPTOM OF HIS SCHIZ- OPHRENIA. NO DISTRESS EVIDENT DURING SAME. ANDREW DID NOT APPEAR PRE-OCCUPIED AND	

CHI no 2104673933
 First name ANDREW DOB 21.4.67
 Last name SMITH Sex: ☒ M ☐ F
 Address 40 IONA WARD.
 BECKFORD LODGE
 HAMILTON.

or attach addressograph label here

Nursing, AHP and Psychological Therapy Notes

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Date/Time (24 hour clock)	Nursing, Allied Health Professional, Psychological Therapy and Other Professional Notes	Discipline/ Designation
	and maintained good eye contact with his visitor throughout. She was not pleased as Andrew had been dishonest with her, she also accused him of selling something from her property which he denied. Andrew stated to her that drugs and alcohol were not the cause of his actions. Andrew stated that the reason he was unwell was a result of people making him ill. The visitor also informed that people had been looking for him and Andrew gave permission for her to tell them where he was.	
ONE TO ONE	One to one carried out with Andrew. Appropriate during interaction and good eye contact maintained. Andrew rates mood as 5/10 and denied any thoughts of self harm, the	



Patient name: ANDREW SHAW.

CHI number: 2104673933.

Date/Time (24 hour clock)	Nursing, Allied Health Professional, Psychological Therapy and Other Professional Notes	Discipline/ Designation
	uninformed he had previously attempted suicide in past, however, it would not be worth his while as the 'voices' have told him they would go with him and he has no escape from same. Andrew also informed that the voices were telling him not to speak to another as she was not on his side. Andrew informed he wants to get well for the first time in his life as he has suffered for over 30 years. Support and reassurances given to Andrew. Next one to one 6.2.16.	
2005	Andrew has been settled in mood and manner. No evidence of any psychotic symptoms upon non-obtrusive observation. Time spent utilising free time. No concerns No overt anxiety or distress observed.	Agg
06/01/2016 06:25hrs.	Andrew fairly settled in shift, no spontaneous interaction offered. No psychotic symptoms or related behaviours evident. He is happy and relaxed to bed and appears to have slept all night. No change to risk review at time of writing.	Agg
		W. Shaw

CHI no 2104673933
 First name ANDREW DOB 21.4.67
 Last name SHAW Sex: ☒ M ☐ F
 Address 40 IONIA WARD
 BECKFORD LODGE
 HAMILTON.
 or attach addressograph label here

Nursing, AHP and Psychological Therapy Notes

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Date/Time (24 hour clock)	Nursing, Allied Health Professional, Psychological Therapy and Other Professional Notes	Discipline/ Designation
6.2.16	1:1 carried out as per care plan.	
1:1	SUBSTANTIAL STARTS HE IS EXPERIENCING	
CPA	AUDITORY HALLUCINATIONS MORE THAN ONE	
1:1	VOICE, DIFFERENT GENDERS WHICH ARE TELLING	
	HIM NOT TO TAKE MEDICATION OR FOOD	
	AS THEY MAY BE POISONOUS. REPORTS	
	HE HAS N/AUT COME IN WITH AN	
	TREATMENT LONG TIME IN THE PAST	
	DUE TO THIS DENIES ANY SUICIDAL	
	THOUGHTS PLAN OR INTENT. OBSERVED	
	NOT TO BE WRITING HANDS INITIALLY AN	
	POOR EYE CONTACT, SMOOTH BUT AS	
	INTERVIEW PROGRESSING HE BEGAN TO RELAX	
	EYE CONTACT MAINLY AN SPEECH	
	BECAME LESS PRESSURE. HAPPY TO REMAIN	
	IN HOSPITAL AT PRESENT TO BE ASSASSINATED.	
	CARE PLAN ASSESSMENT LAMINA ONWARDS.	SR
6.2.16	APPROACH NURSING. START COMPLAINTS OF	
1230	ASITATION. LONG CORAZALAN ACCALITY AT	
	0900 HRS WITH SEVERAL EFFORTS. HAS	
	ATTACHED VIDEOS HAVE FOR BREAKFAST AND	
	LUNCH AN HAVE APPETITUS THROUGHOUT.	SR
6/2/16	Start almost all of afternoon	
2100	and evening using furniture in his	
	room. attended dining room at	
	mealtire and engaged a conegat	
	meal which he shared with a	
	yellow patient. No interaction	
	offered and appears happy at	
	present to stay away from	
	the other patients. No problems	
	found.	SR



Patient name: Andrew Shaw

CHI number: 2104673933

Date/Time (24 hour clock)	Nursing, Allied Health Professional, Psychological Therapy and Other Professional Notes	Discipline/ Designation
12/16 0630	Andrew settled sleep well over night. No concerns	A. Beattie
7/2/16 1320 hrs	Andrew has maintained a low profile this duty with time spent mostly in sideroom writing letters. Attended dining room for meals and accepted a good diet. Winter requested next of kin details and Andrew has given his daughter name, address and telephone number but states he does not want her contacted at present. Andrew states his friend will visit today as he has a key to his home and will bring clean clothing. Andrew continues to appear pre-occupied and appears to be responding to internal stimuli but has offered no complaints. Advised to seek staff for support with any concerns.	
1920 1:1 CPE	Andrew has maintained a low profile, this duty. Andrew has utilised some time out within his room. Good diet accepted. 1x1 interaction carried out with Andrew's consent. Spoke to Andrew about his mental health. Andrew reports he has heard voices for over 30 years and he has not "grassed them up to the doctors". He reports he has had enough of them. Andrew admits his voices tell him to fight and argue with others, this is why he cannot make friends as the voices make him paranoid against friends. Andrew reports writing in his notepad helps distract him from the voices. Andrew denies any thoughts of DSH or harm to others. Andrew reports he thinks has thoughts of suicidal ideation "but what would be the point" he denies having any plan or intent to commit suicide. Andrew spoke about his diet and reports he has good appetite but eats junk food. He reports his sleep pattern is poor	A. Pashley

CHI no 2104673933
 First name Andrew DOB / /
 Last name Shaw Sex: ☐ M ☐ F
 Address

 or attach addressograph label here

Nursing, AHP and Psychological Therapy Notes

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Date/Time (24 hour clock)	Nursing, Allied Health Professional, Psychological Therapy and Other Professional Notes	Discipline/ Designation
7-2-16 Cont.	due to hearing the voices. Andrew reports his mood is 3/10. Andrew has no concerns regarding his care and treatment, his hope for the future is to be free from the voices, he is hoping medication can help with this. Andrew reports he used to take medications but when the voices killed his consultant he stopped because he did not trust any other doctors, voices were telling him his medications were being tampered with by the doctors. Poor eye contact throughout intervention, Andrew did converse freely, noted to be getting more agitated during intervention, uncontrollable hand and feet movement, head moving from left to right. Spoke about anxiety and how he could be anxious getting to know the ward, patients and staff, this is a normal reaction. Agitation increased during review and Andrew accepted 1mg Lorazepam as per Kardex for relief of same. Andrew also utilising time out within his room to write in his notebook. Care Plan remains relevant at this time. MSSV and <i>[Signature]</i>	



Patient name: Andrew Shaw

CHI number: 2104673933

Date/Time (24 hour clock)	Nursing, Allied Health Professional, Psychological Therapy and Other Professional Notes	Discipline/ Designation
7.2.16	urinalysis obtained. DOA sent cont. to lab. No concerns raised with ward urinalysis. Andrew has stated he will seek out staff if he feels agitated or anxious.	SW Merran
8.2.16	Andrew quiet in presentation and behaviour as per usual. No significant problems prior to admission. No change to current risk review.	
1330	Andrew woke with prompting today. Attended to his own hygiene needs. Andrew has accepted a good diet. Andrew has maintained a low profile on the ward, offering interactions on a needs only basis. Andrew's care and treatment was reviewed at today's MDT. Full report in MDT notes in ICP. Andy continues to state he hears voices. To continue to assess Mental State, general behaviour, emotional state and personality issues. Dr Jonathan will see Andrew on a 1:1 basis.	SW Merran
8.2.16	1:1 carried out as per care plan. 1:1 continues to be accepting of current care and treatment. Some anxiety present during treatment. Reports to having heard voices for 30 years. Denies any suicidal ideation plan or intent. Obscurely no overt symptoms of psychosis in evidence. During supervision visit noted to be pleasant, speech coherent, good eye contact and interacting at a high level. RMO Dr Jonathan carried out 1:1 with Andrew notes to follow.	
8.2.16	Seriously evaluating no concerns or concerns noted 2030 An Manner appropriate. visited by his wife. An appropriate treatment.	J PARKY

CHI no 2104673933
 First name ANDREW DOB / /
 Last name SHAW Sex: ☒ M ☐ F
 Address

 or attach addressograph label here

Nursing, AHP and Psychological Therapy Notes

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Date/Time (24 hour clock)	Nursing, Allied Health Professional, Psychological Therapy and Other Professional Notes	Discipline/ Designation
09/02/16 06:30hrs	Andrew didn't eat any supper. Andrew seemed to be suspicious about taking his medication, he asked "what is it?" - staff explained it was Solpade 100mg and that he had discussed it with the consultant earlier on in the day. - Andrew didn't seem to think so. Andrew administered the drug - no other concerns. Objectively no delusional thinking voiced, and no paranoid behaviour evident - thus Andrew appeared to have slept throughout the night. Risk review remains relevant at time of writing.	WB Runt Dwe
9/2/16 1x1 - cpe	Andrew was sitting on his bed, Andrew appeared anxious and preoccupied. Witter asked how he was feeling. Andrew stated that "he was feeling ok he just can't relax around many people. Andrew stated that he hears many voices. Witter asked if they were asking him to do anything to himself or anyone else. Andrew stated they state this all the time, that's why he uses his time out in his room. Andrew states that he has heard voices for 22 years, that's why he has had no friends and has fallen out with his family. States that's why he gets into trouble. Also states that he is worried also, as it's the only company he has had for for 22 years. Andrew states that he only ever trusted his old psychiatrist, however two voices told him they killed her. States that he is willing to get help now he can't keep pretending that he's "ok". Andrew's eye contact was very poor,	



Patient name: **Andrew Shaw**CHI number: **2104673933**

Date/Time (24 hour clock)	Nursing, Allied Health Professional, Psychological Therapy and Other Professional Notes	Discipline/ Designation
	Andrew was clenching his hands through out the conversation. At this point Andrew became quiet and was staring around the room. Writer ended the interaction as not to agitate him anymore. Andrew was advised to approach nursing staff at any point to voice any concerns or worries. Andrew states that he will do this. Risk Assessment and care plan remain valid at time of note.	M. Davelle
9.2.16. 12:40	Andrew awake at commencement of duty attended to own personal care. Andrew had a good diet intake. Medication accepted as per Kardex. Andrew has spent long periods of time this duty in his side room. Andy stated that he "needed some time out." Andy remains quiet in presentation also preoccupied at times. However no nursing concerns at time of note.	M. Davelle
9.2.16 2000	ANDREW HAS HAD A SEVERE FALLS. GOOD DIET ACCEPTED. NO OVER SYMPTOMS OF PSYCHOSIS IN EXAMINATION.	✓
10/2/16 06:45 AM	Andrew sitting Patient Retaining To Bio. No change To current Risk Review.	✓
10.2.16 1230	Andrew has an attempt to remove cath without problems. Asymptomatic for Anxiety, no over symptoms of psychosis. Good Diet Acceptance. No problems noted.	✓
20:30	Andrew states ^{error} he is "fine" and offering no concerns. Yet appears pre-occupied at times. Good diet accepted. Reminded to approach nursing staff if he needs anything.	(EMN) Surguhat
11/2/16 06:30 AM	Andrew sitting Patient Retaining To Bio. No change To current Risk Review	✓

CHI no 2104673933
 First name Andrew DOB 21/4/67
 Last name Shaw Sex: ☐ M ☐ F
 Address

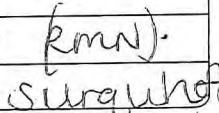
 or attach addressograph label here

Nursing, AHP and Psychological Therapy Notes

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Date/Time (24 hour clock)	Nursing, Allied Health Professional, Psychological Therapy and Other Professional Notes	Discipline/ Designation
1320	Andrew awoke with prompting this morning, he appears quiet and interacts at a minimum. He keeps his head down and offered no complaints. Showing no signs of responding to unseen stimuli.	
11/2/16 19:15	1:1 carried out with Andrew, poor eye contact throughout same yet 1:1 stated he was happy to talk. Andrew states he has had 'a bad past few days' with voices in his head, could not elaborate on what these voices were but stated he felt like people were talking about him. Reassurance given and accepted. Andrew said he benefits from time out in room and feels anxious in dining room due to too many people around him. Andrew was wringing his hands throughout 1:1, states that distracts him from the voices, did not appear to be distracted during conversation. Asked staff if tablets (sulpride) contained "poison", reassured re: same. Andrew says he will take medication but is yet to feel a benefit from same. Reminded that staff were here to support him and he should approach us if he needs. No objective signs of psychosis during interaction.	



Patient name: Andrew Shaw

CHI number: 2104673933

Date/Time (24 hour clock)	Nursing, Allied Health Professional, Psychological Therapy and Other Professional Notes	Discipline/ Designation
11/2/16 20:00	Andrew continues quiet in presentation. 1:1 carried out. Good diet accepted. / (RMN) No further concerns. —————	Surquhot
S/R	Andrew approached writer at 20:15 requesting PRN medication stating he was agitated. Some mild agitation noted, encouraged Andrew to utilise time out in low-stimuli environment. Later approached writer and still felt agitated. PRN 1mg Lorazepam (RMN) given at 20:50 for agitation. /	Surquhot
12/2/16 0640	Low profile maintained around ward. Attended dining room for supper and retired to bed after nocte medication. Settled and appears to have slept well overnight. No change to risk review.	Dehon
12.2.16 0930	ANDREW STATES HE WAS FEELING UNWELL ANY UNWELL TO ATTEND DINING HALL FOR BREAKFAST. DISCUSSED FURTHER ANY HE COULD NOT PINPOINT REASON STATE "DON'T KNOW IF PHYSICAL OR MENTAL HEALTH" BP, TEMP O ₂ SAT RES _{TS} RECORDS IN PHYSICAL OBSERVATION CHART ALL WITHIN NORMAL LIMITS. NO OTHER SYMPTOMS OF PSYCHOSIS, ASYMPTOMATIC FOR ANXIETY SOME LETHARGY SUGGEST ANY RESOURCING OFFERED. AM CONTINUE TO MONITOR PHYSICAL STATE AND OBSERVE/ASSESS MENTAL HEALTH.	SB
1105	Phone call received from Ann Marie Cain to advise she was completing report for court in relation to Andrews assessment. Update given to Ann Marie Cain and she advised that ~~she~~ ^{now} Andrew owns several properties and has neighbour who advised staff she had only known him for	

CHI no 2104673933
 First name ANDREW DOB 21/4/67
 Last name SHUN Sex: ☒ M ☐ F
 Address 90 IONIA WARD
 BELKFORD LODGE
 HAMILTON.
 or attach addressograph label here

Nursing, AHP and Psychological Therapy Notes

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	eight months has in fact been in Andrews life since 2005 and that information was given to Ann Marie from Andrews previous MHO. Ann Marie is under the impression that they together own and rent out several properties around Glasgow. The opinion from previous MHO is that Andrew has presented in the same way previously when given sentence for road traffic offences. Ann Marie advised she will have report complete in next few days.	
12.2.16 1230	Andrew Less lethargic and actively visiting Hall for lunch soon after. Aspirin for Anxiety. NO other symptoms of psychosis.	
S/N	Discussed family/next contact for consent Andrew unwilling to consent to same as previous same carers name and contact number. Documented in section 14 of ICL.	



Patient name: **ANDREW SHAW.**CHI number: **2104673933.**

Date/Time (24 hour clock)	Nursing, Allied Health Professional, Psychological Therapy and Other Professional Notes	Discipline/ Designation
12-2-16 2000	Andrew has maintained a low profile on the ward. Andrew complained of feeling agitated before dinner, advised some time out within his room until dinner was ready, would be better than medications. Andrew accepting of same. Unobtrusive observations commenced. Andrew spent the time in his room writing in his note pad and eating foodstuff. No other complaints offered. Good diet accepted for dinner. Andrew has used the pay phone on occasion. Very little interactions with fellow peers. No evidence of psychotic symptoms. No obvious head movements observed.	
13/2/16 06.30hrs	Andrew accepted supper. Andrew at medication time, explained to nurses that he was having trouble swallowing his tablets, and has requested if possible, he would switch to liquid form - request has been put in the diary for Monday - Andrew aware of the same. No other distressful thoughts or any related behaviour. Retired to bed and appears to have slept throughout the night.	S/M Duncan
12 40	Andrew woke with prompting from staff. Did not attend to hygiene needs. Andrew accepting of all diet and prescribed medications. Andrew has maintained a low profile this duty, spending time utilising his free time within his room. No complaints of agitation, none evident on observation. No evidence of psychotic symptoms.	WB Rana
20-10	Andrew has spent a large majority of duty in his sideroom this duty. Andrew	

CHI no. 2104673933
 First name ANDREW DOB 21.04.67
 Last name SHAW Sex: ☒ M ☐ F
 Address

 or attach addressograph label here

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	approached nursing staff for "one of those anxiety tablets". Andrew was given 1m of Lorazepam. Andrew appeared agitated, stated that the voices where to much. Andrew has also requested if someone could go to the cashline and lift him money. Advised Andrew to speak to nurse in charge tomorrow. Andrew accepted a good diet, medication as per Kairdex. Andrew has been advised to approach nursing staff to vent any concerns. Andrew accepting of this.	M. Lawell
14/2/16 0645	Appeared fairly settled around ward environment, however minimal interactions offered. Andrew noted to be helpful and assisting fellow patient at supper time. Retired to bed after nocte medication. Appears to have slept well. No change to risk review.	
14/2/16 13:20	Andy required some encouragement from nursing staff to rise and join his fellow peers in the dining room for breakfast. He stated that he was agitated although this was not evident from nursing staff present. There was no overt indication of anxiety or psychosis either. He eventually joined his peers after some reassurance from staff. No other concerns at time of writing.	
	20.10 Andrew has had a quiet duty, offering little interactions with peers or staff. At dinner time a fellow peer CR stroked	



Patient name: Andrew Shaw

CHI number: 2104673933

Date/Time (24 hour clock)	Nursing, Allied Health Professional, Psychological Therapy and Other Professional Notes	Discipline/ Designation
	Andrew's ear, Andrew allowed this and didn't say anything to patient. Staff intervened, Andrew didn't appear distressed by this and stated he was "OK". No complaints offered by Andrew.	SSB
16/02/16	Andrew appearing relaxed and appropriate in behaviour.	
06:20hrs	Andrew ate a small diet at supper time. Andrew accepted NRB indications - originally Andrew had requested that his solids be changed to the liquid form, however stated he would prefer to stay with the tablet form. Retired to bed and appears to have slept throughout the night. Risk review remains relevant at time of writing.	W. Brown
1415	Andrew reluctantly got out of bed this morning, stating "no, no, no" he wasn't getting up and he wanted to go back to Prison. He requested PRN medication Imgy lorazepam ~~s~~ utilised @ 10am with good effect. Andrew was seen at MDT, Andrew states he has not been having a good few days. He spoke to doctor and described that he felt people were trying to take stuff off of him although vague who those people were. Please see MDT notes for full report. Gave Andy RES 1 information leaflet and explained same.	SSB
15/2/16	Smoking reviewed. Andrew is a non smoker therefore doesn't need NRT at this time.	
14:50		dyf
2015	Andrew has been quiet on the ward this dmth. No overt evidence of any anxiety or distressed and no evidence of any psychotic	

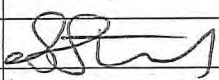
CHI no 2104673933.
 First name ANDREW DOB 21.04.67
 Last name SHAW Sex: ☒ M ☐ F
 Address 4010NA WARD
 BECKFORD LODGE
 HAMMILTON.
 or attach addressograph label here

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	phenomena. Interacted well with staff and peers. No concerns raised.	
16/02/16 06:25hrs	Andrew ate supper, accepted NOKB medications, retired to bed without incident. Appears to have slept throughout the night. Risk review remains relevant at time of writing.	W. Bruce Rmt.
1320	Andrew has been quiet this duty, required encouragement to rise. He slept on and off in dayroom most of duty, showing no signs of anxiety and also no evidence of psychotic symptoms.	
2045	Andrew continued quiet this afternoon. Received a female visitor this afternoon. During visit Andrew's speech content was appropriate, Pleasant on approach. Offering no complaints. Attached to his laundry this evening. No chef taken at mealtime. Andrew given his bank card to give to his friends so they could get money for him.	P. L. O. g
17/02/16 06:30hrs	Andrew ate supper, accepted NOKB medications, retired to bed without incident. Appears to have slept throughout the night. Risk review remains relevant at time of writing.	W. Bruce Rmt.
17.2.16 1230	phonecall received from Ann Marie Cairn to inform she had contacted Kellyanne Fulton who Andrew claims is his daughter. Ann Marie informed that this	



Patient name: ANDREW SHAW.

CHI number: 2104673933.

Date/Time (24 hour clock)	Nursing, Allied Health Professional, Psychological Therapy and Other Professional Notes	Discipline/ Designation
	female states that she is not his daughter and Andrew was her deceased father's friend. If Andrew was her father then he would be ten when she was born. Ann Marie stated that Kelly Ann informed her that Andrew gets benefits paid to her house and uses her address for things and she has not seen him for several months. Ann Marie is under the impression that this girl has learning disabilities and may be a vulnerable adult. Ann Marie advised that she will gain more information about this female and file for adult support and protection if necessary. Ann Marie also advised her report was complete.	
1300	Andy awoke with some prompting, accepted good diet. He has utilised time in his room, offering no complaints.	
13.15	1.1 with Andy, Andy interacted well at first he appeared agitated stating he came into his room to "get peace", enquired what he meant by this he stated his voices were worse when he	

CHI no
 First name Andrew DOB / /
 Last name Shaw Sex: ☐ M ☐ F
 Address

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1315	was surrounded by people. Staff questioned what his voices were saying he appeared reluctant to disclose although eventually stated they were calling him a "fat b-----d" and "not to talk to me". Staff started to talk about Andrew's interest in cars and he communicated clearly and showing no agitation or signs of psychosis when talking about this subject and interacted passionately while discussing this. He stated he used to buy cars off of Gumtree and sell them on, he stated he used to buy and sell buses to a local bus company and this was how he had made a living. He disclosed he felt he was self medicating with "valium" and "cocaine" as he was taking drugs regularly staff enquired if he was in any debt with drugs, he stated no that "he" had friends who gave" and then he stopped talking and refused to disclose anymore regarding this subject. Advised Andrew if he had any issues or felt agitated it would be beneficial to discuss with staff	



Patient name: Andrew Shaw

CHI number: 2104673933

Date/Time (24 hour clock)	Nursing, Allied Health Professional, Psychological Therapy and Other Professional Notes	Discipline/ Designation
	how he was feeling instead of isolated himself in his room. He agreed to same. No other issues offered. ~~care Evaluation~~ care plans remain valid and ongoing.	
17/2/16 15:50	Corection reviewed, Andrews assessment continues, encouraged to talk to staff and use time out in his room when he feels anxious or unwell. Continues to request PRN medication on occasion but manages without care. Interacting well when being observed unobtrusively and no signs of mental illness during the times. Does continue to complain of voices.	288 ✓
21:00	Enjoyed a comfy out meal shortly after complaining of feeling anxious and unsettled. Observed prior to request laughing and joking with fellow patients. Advised to use breeture in his room to see if feeling subdued. No signs of mental illness when being observed unobtrusively but does display strange hand gestures and facial movements when he knows he is being watched.	gpk
18-2-16 06:05	Andrew accepted supper and nocte medications before retiring to bed. Good sleep gained over night. No evidence of distress or agitation, no complaints offered. No evidence of psychotic symptoms. No change to risk review.	SPK
18/2/16 13:00	Quiet morning spent mainly sleeping. Good diet taken and got a fellow-	S/N Deerican

CHI no 2106673933
 First name Andrew
 Last name SHAW
 Sex: ☐ M ☐ F
 Address

Nursing, AHP and Psychological Therapy Notes

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18/2/16	Patient to get him crisis, give continues and a loaded sweatshirt. Little interaction offered but appropriate when care engaged.	
20:45	Andrew has presented as quiet and maintaining low profile. Made a phonecall to DHSS to sort benefits, coped well with phonecall and managed to articulate well during same. Appropriate in conversation and no evidence of any anxiety or psychosis noted. No concerns.	(RN) Surgeon
18/2/16 23 ⁰⁰ Hours	SHORTLY AFTER NIGHT TIME SUPPER TIME, ANDREW APPROACHES STAFF STATIONER THAT APPROXIMATELY "TWO DAYS AGO" AND "THE DAY AFTER HE WAS ADMITTED" TO LONA, EITHER FELLOW PATIENT IF OR FELLOW PATIENT DRB SOLD HIM A PREGABALIN 300MG FOR £1.00 ANDREW DENIES TAKING SAME AND SUBSEQUENTLY PRODUCES A PREGABALIN 300MG CAPSULE. ANDREW STATES THAT HE BELIEVES SAID PATIENTS OBTAIN THIS DRUG EITHER FROM DRB'S BROTHER OR FROM A PATIENT IN CATHICA WARD, HOWEVER, ANDREW COULD NOT NAME SAID PERSON. ANDREW STATES HE HAS NOT WITNESSED ANY MORE EVIDENCE OF DRUG SELLING OR TAKING SINCE THEN. ANDREW DID ADMIT HOWEVER, THAT ON ADMISSION HE DID NOT KNOW WHAT PLAGET HE WAS ON "ANDREW'S ROOM WAS SEARCHED WITH HIS FOOD AS WAS A SEARCH OF HIS PERSONS. ANDREW ALSO STATES TO STAFF	



Patient name: Andrew SPAW

CHI number: 2104673933

Date/Time (24 hour clock)	Nursing, Allied Health Professional, Psychological Therapy and Other Professional Notes	Discipline/ Designation
18/2/16 23 ⁰⁰ Hour	Continues to be a FELLOW PATIENT YF WAS BULLYING CTR REASSURANCE GIVEN TO Andrew During Interaction Staff John Andrew To Be Inconsistent During Conversation.	P.B.
19.2-16	Andrew declined supper, accepted no medication. Andrew made allegations towards fellow peers on the ward. See previous entry. Andrew slept well overnight. No change to risk review.	S/K K. Durcan
19/2/16 13:15	Andy arose after some encouragement from staff. Diet and medication accepted. Andrew appeared agitated upon occasion when in the company of nursing staff by demonstrating what appeared to be dyskinesia. However he appeared asymptomatic when witnessed via unobtrusive observations. Andrew also received a call from the DWP regarding his ESA benefits now that he is being detained in lone ward. Andrew coped well with the call and did not appear to be distressed by any psychotic phenomena. No concerns raised by Andrew with regards to any unmet nursing needs.	Rob
19:40	Andrew received a visit from his friend/land-lady today. Andrew appeared to engage very well in conversation with his friend, maintaining good eye-contact and offering appropriate conversation. He appeared lucid with no evidence of responding to auditory stimuli. Andrew became tearful when discussing acquaintances from his past however did not appear distressed by same. Andrew states he enjoyed the visit with his friend. Good diet and medication accepted with no complaints offered to staff. Spending free time in side room and watching TV in day room.	K. Wright
20/2/16 06:30	Andrew ate supper, accepted some medication and retired to bed without incident. Appears to have slept	

CHI no 210672432
 First name Andrew DOB 21/04/67
 Last name Shaw Sex: ☒ M ☐ F
 Address 110 IONA WARD.
 or attach addressograph label here

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(Cont)	Throughout the night. Risk review remains relevant at time of writing.	W Bruce Reid
20/2/16 0800hrs.	Retrospective report from 19/2/16. Room search and personal search carried out with Andrews permission and necessary paperwork signed - nil found. Andrew also provided specimen of urine for D.O.A.	A. Pashley
13:05	Andrew required encouragement to rise and attend for breakfast this morning. Good diet and medication accepted this duty. No evidence of anxiety or psychosis, and interactions have been appropriate in content. Andrew has spent his free time sleeping in his side room. No complaints offered.	K. Wright
2000	Andrew has had a quiet duty, choosing to spend most of his time in his room. Enjoyed a takeaway meal at dinnertime, no evidence of anxiety or psychosis. No complaints offered.	egg
21-2-16	Andrew accepted supper and nocte medications before retiring to bed. No signs of anxiety or evidence of psychotic symptoms. Andrew gained good sleep overnight with no concerns raised. No change to risk review.	Sh. Purcan



Patient name: Andrew Sheen

CHI number: 2104673933

Date/Time (24 hour clock)	Nursing, Allied Health Professional, Psychological Therapy and Other Professional Notes	Discipline/ Designation
21/2/16	Andrew was up in time for breakfast this morning after having a quick wash. Andrew was quite and subdued for the early part of the morning but got more animate as the morning progressed. Andrew spoke to the writer about life in the ward and stated that he feels he has "settled well". There was no new nursing issues with Andrew this duty, mentally appears well with no overt evidence of psychosis -	
2020	Andrew has had a quiet duty utilising most of his time in his room. He did approach staff stating he wanted to speak to someone. Staff enquired what was his concerns, he stated he was ~~advised~~ "fed up" of his voices, when questioned what the voices were saying he stated they were calling him "a grass". Staff enquired why he thought they were saying that he stated it was because he was telling staff "stuff". Staff asked what "stuff" was he referring too but he became vague and wouldn't answer. He stated he had a chip in his ^{head}, staff asked what did he mean he stated he couldn't tell me. Andrew remained quiet and appeared reluctant to talk further. Staff gave reassurances, during the interaction Andrew did not appear distressed and maintained good eye contact throughout interaction.	

CHI no. 2104673933
 First name Andrew DOB/...../.....
 Last name SUNAW Sex: ☐ M ☐ F
 Address
.....
.....
 or attach addressograph label here

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22-2-16 0855	Andrew accepted supper and nocte moderations before retiring to bed. No evidence of psychotic symptoms. No distress or agitation noted. Andrew slept well overnight. No change to risk review.	SN, K Durran
1250	Andrew was prompted to rise this morning, poor diet accepted. He spent most of duty sleeping in the quiet room. He was seen at MDT today, Andrew reports his week has not been good. ~~He~~ He states voices say "bad things to him all the time" and they say "medication is poisoned". He states medication makes no difference and referred to the chip in his ~~brain~~ brain. Andrew agreed to accept depot injection, prescribed Risperidol Consta to be given on Friday 26/02/16. Assessment for next week to conclude if Andrew is fit to plead at court.	SSW
1325.	Phone call from Anne Maure Kane, she will attend MDT next week.	SSW



Patient name: Andrew ShawCHI number: 2104673933

Date/Time (24 hour clock)	Nursing, Allied Health Professional, Psychological Therapy and Other Professional Notes	Discipline/ Designation
22.2.16 2.00	No Problems or concerns. Asymptomatic for Anxiety NO overt symptoms of psychosis. Good Risk Acceptance.	SV
23.2.16	Andrew accepted supper and nocte medications before retiring to bed. Andrew woke up at 0100 hours to complain of uncontrollable leg movements. Andrew requesting PRN Lorazepam, explained the PRN blue tablet he is asking for would not combat this, Andrew accepting of same and returned to bed, good sleep gained overnight with no further concerns raised. No change to risk review.	SV A. Durcan
12.55	Andrew arose with some prompting he accepted good diet. Spent most of duty utilising time in his room sleeping. Showing no signs of agitation or distress. No complaints offered.	SS
pm 20.45	Andrew has had a quiet evening with no complaints. Andrew showered this evening and attended to his laundry without any assistance to use the washing machine. Andrew enjoyed a visit from his friend/landlady and was appropriate during visit with good eye contact and concentration. Speech content centred around properties and moving money to different bank accounts. No overt symptoms of psychosis or anxiety at time of report.	A. Pashley
24.2.16 0600	Andrew accepted supper and nocte medications before retiring to bed. Good sleep gained overnight with no concerns raised regarding mental health. No change to risk review.	SV A. Durcan

CHI no 2104673933
 First name Andrew DOB / /
 Last name Shaw Sex: ☐ M ☐ F
 Address
 or attach addressograph label here

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24.2.16 1230	AROSE AND ATTEMPT TO PERSONAL CARE WITH MINIMAL PROMPTING. SETTLER MORNING ASYPROMARK FOR ANXIETY AND NO OTHER SYMPTOMS OF PSYCHOSIS. EASY DIRT ACCEPTS AT BREAKFAST AND LUNCH.	SPan
20:20	Andrew has maintained a low profile around the ward this evening. Pleasant and appropriate on interaction with no evidence of psychotic symptoms or agitation. Good diet taken at dinner time. Andrew has spent free time relaxing in quiet room.	K. Wright
25/2/16 06:30AM	Andrews appearing bright in mood when interacting with fellow peers at supper time. Andrews accepted his NIGHT medications, although stated that he had "shaky legs" since he started his new medication (Risperidone), and that it had kept him up all night. The previous night, he was wondering if he wasn't written up for Risperidone for this side effect. Writer advised that he wasn't. Writer advised Andrew that they would assess him throughout the night for his complaint. Writer has been on for the last 2 nights and has observed Andrew to having a good sleeping pattern without any incidents or concerns. - At approx 00:15hrs, Andrews stated to staff, he wouldn't be taking this new medication because of the side effect, as he won't get any sleep. Next check, Andrews was sound asleep and appears to have slept throughout the night. Risk review remains relevant at time of writing.	W. Bruce RMD
25/2/16 13:00	Quiet morning, slept in dayroom and using quiet time / free time in his room. appears to be interlocking	



Patient name:

CHI number:

Date/Time (24 hour clock)	Nursing, Allied Health Professional, Psychological Therapy and Other Professional Notes	Discipline/ Designation
	well with select patients with no signs of mental illness during care. Good diet taken and no complaints offered.	8/22
21:00	Andrew continues settled relaxed and on good form with fellow Peers.	
⊕	Telephone call from a gentleman who was enquiring about a message which had been left from Jamie's Phone. The gentleman had said it was most likely from Andrew ^{Shaw} and he had been abrupt and rude in manner to the person who took the message. Staff member Jean Boothman asked patients if they had made any calls. Andrew denied Son he had made the call to gentleman however agreed with various other people he had contacted. When speaking to Andrew in private he continued to insist he had spoken to the gentleman only naming others. Eventually he said he had admitted to phoning gentleman but denied being rude. He then called the gentleman in presence of staff at his request. (Cathie) The caller was the gentleman's son. Staff heard this as Andy requested same. The son had said he felt Andrew was very cheeky and Andrew requested his dad contact him.	McKinstry Present
26/2/16 15 ⁰⁰ Hours	UNUSUAL COMMENTS WITH ANONIM THIS DUTY WITH HM SCORING 56 WHICH IS IN THE CATEGORY OF MEDIUM SCORING. ANONIM CITES THAT HIS MAIN PHYSICAL CONCERNS WERE RESTLESSNESS AND SHAKINESS. ANONIM ALSO IDENTIFIED RIS PERMANENT SUCH AS URINE DARKEN THAN USUAL AND FLUSHING OF THE FACE. ANONIM HAS HAD A QUIET DUTY SPENT IN COMPANY OF PEERS	J Boothman
26/2/16 21 ⁰⁰ Hours	ANONIM COMMENTS BPAS WITH A SCORE OF 35 CONTINUATION. ANONIM SCORES HIGH IN ANXIETY AND LOW MACH. AS WELL AS FLAUNCEMENTARY BEHAVIOUR. ANONIM STATES THAT HE HEARS VOICES REGULARLY DEPOT MEDICATION	

CHI no. 2104073933
 First name Andrew DOB 21/04/67
 Last name SIMON Sex: ☐ M ☐ F
 Address 7, LONA WANA,
 SIMON LODGE
 or attach addressograph label here

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26/2/16	Cont. obs. ADMINISTERED LEFT SIDE AT 20 ³⁰	
21 ⁰⁰ Hours	Hours. NEXT DUE 11/3/16. Andrew ALSO PROVIDES ~~AT~~ WITH INFORMATION AND A LEAFLET on RISPERDAL CONSTA.	
26/2/16	1-1 INTERACTION. Andrew EXPRESSLY CONCERNED AT Being PRESCRIBED A Depot INJECTION AND REPEATEDLY ASKES IF THE INJECTION WAS POISONOUS. Andrew ALSO INQUIRED AS TO WHAT HE WAS ON ORAL MEDICATION AS WELL AS THE INJECTION. Andrew GIVEN REASSURANCE REGARDING SAME.	
27/2/16	Andrew was quiet prior to retiring. 0615 Settled quickly and slept throughout room the night. Risk review relevant.	Mukher
1245	ANDREW ENCOURAGED TO RVE THU OUT. HAD SPENT TIME WITHIN SIDE ROOM. GOOD DIET ACCEPTED AT BREAKFAST AND LUNCH. SUPERVISED TO IRON CLOTHES. NO EVIDENCE OF PSYCHOTIC SYMPTOMS. PERSEANT AND APPROPRIATE IN MOOD AND MANNER.	
2010	Andrew appears to be quiet this duty, utilising time in his room. He had a takeaway at dinnertime and accepted a good diet. Requested a bath this evening, offering no complaints showing no signs of distress or psychosis.	
28/2/16	Andrew quiet prior to retiring. 0630 appears to have slept well overnight. Risk review remains relevant.	Mukher



Patient name: Andrew Shaw

CHI number: 2104673933

Date/Time (24 hour clock)	Nursing, Allied Health Professional, Psychological Therapy and Other Professional Notes	Discipline/ Designation
13.15	Andrew has appeared quiet this duty, spending most of his time within his sideroom. Good diet accepted and showing no signs of agitation or psychosis. No complaints offered.	SSG
28/2/16 2000	Settle evening no problems or concerns. Asymptomatic for Anxiety. No overt symptoms of psychosis.	SR
29-2-16 0540	Andrew accepted supper and night medications before retiring to bed. Good sleep gained overnight with no concerns being raised. No change to risk review.	SR
1330	Andrew was prompted to rise this morning, he accepted good diet and offered no complaints. Andrew was seen at MDT today. MHO Anne-Marie Carr attended discussion was had regarding Andrew's presentation and if his mental health issues were ~~severe~~ severe enough would impact him standing trial. It was decided although Dr Jonathan believes he does have mental health issues these are not severe enough for him not to stand trial. Andrew was made aware of this, G4S booked for tomorrow as Andrew has court at 10am in Pausley.	SR
19:50.	Andrew continues as same. No objective signs of any anxiety or poor mental state. Attended to personal care and laundry independently. NO concerns.	(PMN) SSG