Independent Review Panel for NHS Continuing Healthcare - Ms Agnes [redacted]

Comparison of assessment domains

Norfolk, Suffolk and Cambridgeshire SHA People with Dementia Criteria

Criteria	PCT's assessment	IRP comment
Have a severe and persistent degree of behavioural disturbance, which requires: - • Psychiatric intervention • Covering continuous assessment • Intensive treatment	Ms [redacted]' was reviewed by Psychiatry in December 1998 and this evidences that there was no indication for Psychiatric intervention, continuous assessment or intensive treatment. Ms [redacted] was diagnosed with Dementia in June 1996, however no specialist treatment was advised.	Ms [redacted] was severely cognitively impaired and therefore was disorientated as to time, place and person. She had poor long and short term memory and struggled to make choices or assess risk. She had periods of anxiety and restlessness, showing episodes of challenging behaviour at times. Ms [redacted] had been on Aricept in the past and hadl been seen by psychiatrists due to her diagnosis of dementia but the Panel could find no indication that Ms [redacted] suffered with severe or persistent behaviour which had required any psychiatric intervention, intensive treatment or continuous assessment.
Management carried out by a skilled person qualified in mental health, eg psychologist, mental health nurse, consultant psychiatrist. Common examples of problems might be: • severe and persistent violent behaviour • grossly disinhibited sexual behaviour • unpredictable medical condition • a risk of harm to self and others if not receiving observation and intervention • grossly disinhibited anti-social behaviour, e.g. persistent screaming and shouting • defecation/urination inappropriate areas	There is no evidence that Ms [redacted] displayed any violent behaviour during the period under construction. There is no evidence that Ms [redacted] displayed any disinhibited sexual behaviour during the period under consideration. During the period under consideration Ms [redacted]' medical condition remained stable. Whilst the Panel acknowledge that Ms [redacted] required supervision to maintain safety, specialist intervention was not required. There is no evidence that Ms [redacted] displayed any vocal behaviour during the period under consideration. Ms [redacted] was incontinent, however there is no evidence that there were any episodes of inappropriate urination or defecation during the period being considered.	The Panel could find no indication that Ms [redacted] had required input from a skilled mental health professional during the period under review. Ms [redacted] did not show severe or persistent violent behaviour and there was also no indication of disinhibited sexual behaviour. Ms [redacted] did not appear to show persistent screaming or shouting and there was no indication from the records available of inappropriate defecation or urination. While Ms [redacted]' behaviour potentially posed a risk to herself due to her removing her lap strap, she had not required input from a mental health professional concerning her behaviour during the appeal period. The Panel could find no indication that Ms [redacted] had an unpredictable medical condition.

People with dementias that also have a severe and persistent degree of behavioural disturbance, which requires on-going inpatient psychiatric, psychological or nursing assessment, treatment or management	There is no evidence that Ms [redacted]' needs were such that any periods of inpatient psychological or nursing assessment, treatment or management were indicated during the period under consideration.	The Panel agreed that Ms [redacted] did not appear to show a severe or persistent degree of behaviour which required inpatient assessment, treatment or management.
People with dementias that also have severe and persistent psychiatric disorder where the behaviour has not fully responded to intensive treatment and rehabilitation and will require long-term continuous assessment, treatment and management	Ms [redacted] did not demonstrate severe or persistent psychiatric disorder which required long term continuous assessment, treatment or management.	The Panel could find no evidence to suggest that Ms [redacted] required continuous assessment, management or treatment due to her behaviour not having responded to intensive treatment or rehabilitation.
People with dementias who also have physical problems that require specific care management by specialist members of the multidisciplinary team, in order to reduce risk of significant deterioration of physical health and safety. Consideration will be given to the level of risk of further deterioration if the patient should be relocated.	During the period being considered Ms [redacted] did not require any periods of significant input from members of the multidisciplinary team.	Ms [redacted] did not appear to require input from specialist members of the multi disciplinary team during this period due to the potential risk of deterioration in her physical health or safety.

Criteria	PCT's assessment	IRP comment
Requires extensive healthcare support throughout the 24-hour period because of very complex health needs. This healthcare support is of a type, which can only normally be delivered by a suitably qualified health care professional.	Ms [redacted] required personal care support for: • Moving and Handling • Supervision and monitoring, to ensure falls risk is reduced. • Management of continence and constipation. • Supervision and monitoring of diet and hydration. • Support with washing and dressing. • Monitoring of environment to ensure safety and dignity are maintained. • Admission of medication. The Panel agreed, however, that these needs are not deemed clinically complex and did not require extensive healthcare support throughout the 24 hour period.	Ms [redacted] was bed or chair bound requiring a hoist and two carers for all transfers. She was at risk of falls and had suffered a number of falls during the appeal period and also suffered with flexion deformity in her knees requiring some careful positioning on movement. Ms [redacted] required assistance with feeding and was at risk of choking due to putting too much food in her mouth. She also suffered some weight loss near the end of this period requiring supplements. Ms [redacted] was doubly incontinent and was prone to constipation requiring enemas. She was at high risk of skin breakdown and suffered with blistering to her skin and skin irritation. Ms [redacted] required administration of her medication and monitoring for potential side effects and signs of pain. The Panell agreed that Ms [redacted] had a range of needs but there was no indication she had required extensive support from health professionals over a 24 hour period. There was no indication that her needs were complex or that the care required could only be provided by a health professional.
Specialist medical/nursing assessment or treatment/management on at least a weekly basis, because of complex, unstable or rapidly deteriorating condition.	Ms [redacted] required occasional input from Community nurses, who advised on management of continence that Ms [redacted] had any needs which required specialist medical/nursing assessment or treatment on a weekly basis or evidence of a complex, unstable or rapidly deteriorating condition.	Ms [redacted] required some input from community nurses at times but this was not frequent. The Panel could find no indication that Ms [redacted] required any specialist assessment, treatment or management on a weekly basis. There was nothing to indicate her needs were complex or that her condition was unstable.

Medical interventions because of instability, frequent or unpredictable relapses.	Ms [redacted] medical condition was stable and she did not present with any needs which required frequent review by her GP or any specialist Medical Practitioners. Ms [redacted] was reviewed on a routine basis by her GP. Additionally, Ms [redacted] required GP input, on a few isolated occasions, for minor acute episodes, such as a chest infection in February 2000. These episodes responded to prescribed treatments and did not necessitate ongoing medical review. GP/Consultant statement confirms medical stability at the time of assessment.	Ms [redacted] had required some input from her GP but this was not frequent. The Panel could find nothing to indicate that Ms [redacted] condition was unstable. There was also no indication of frequent or unpredictable relapses.
Frequent or continually available monitoring or adjustment of medication.	Ms [redacted] did not require frequent monitoring or adjustment of medication during the period under consideration. Ms [redacted] required GP input, on a few isolated occasions, such as antibiotics to manage a chest infection.	Ms [redacted]' medication did not appear to have required frequent review or adjustment and while some monitoring was required to look for potential side effects of her drug regime, this was not felt to be frequent.
In certain circumstances NHS funded and arranged continuing care may also be apropriate for people who do not meet all the above criteria, but where it is agreed by the multi-disiplinary team that they have other overwhelming health needs.		The Panel agreed that they could find no indication that Ms [redacted] had overwhelming health needs during this period.

Domain	Claimant's comment	IRP comment
Behaviour	**Moderate** My mother's behaviour was challenging in that she was quite restless at times and a risk to herself in falling out of her wheelchair and falling out of bed. She did not exhibit aggressive behaviour.	**Moderate reducing to Low by early** 11999 The Panel noted that the records indicated that Ms [redacted] could be quite anxious and restless at times. She was also noted to take other resident's food during meal times and would rock forwards and backwards, removing her lap strap. The records did not indicate any physically aggressive or disinhibited sexual behaviour and Ms [redacted] did not appear to be resistive to interventions. The letter from the Consultant Psychiatrist in July 1998 indicated that there were no severe behavioural problems at this time. However, the Panel agreed that her restlessness did lead to some incidents of challenging behaviour. Her behaviour, particularly removing her lap strap, potentially posed a risk but this could be managed by the care staff. The Panel noted that the records suggested that her challenging behaviour was more frequent in 1998 and the Panel agreed that, given the change in environment, it was reasonable to assume that Ms [redacted] was more agitated and anxious for several months until she became more settled.
Cognitive impairment	**Severe** My mother had no short term memory, she was unable to retain any basic instruction. She was unable to make any form of decision regarding her own wellbeing. She was very confused and disorientated at times, often very distressed, crying and talking to the wall. She was unable to assess any form of risk, she had several instances of falling out of her wheelchair if not carefully supervised. At mealtimes she often required supervision since she could not discriminate hot food from cold food. She also would put far too much food in her mouth and vomit if not supervised at meal times.	**Severe** The Panel noted that Ms [redacted] was disorientated to time, place and person and was unable to recognise her family. She had poor short and long term memory and struggled to make choices or assess even basic risk. The Panel noted that Ms [redacted] had scored 22/30 on a mini mental state examination in August 1997 but by December 1998 her score was 10/37 indicating a significant deterioration in her cognition. The Panel noted that Ms [redacted] underwent surgery under a general anaesthetic in July 1998 which was likely to have contributed to the decline in her cognition from this time onwards.
Psychological/ emotional	**Low** There is plenty of evidence that my Mother was distressed at times, not understanding her condition but aware nonetheless that she was ill. She was quite tired and tearful at times	**Low** The Panel noted that Ms [redacted] appeared to suffer with episodes of distress and anxiety and was also noted to be tearful at times. She had a previous history of hallucinations and delusions although |

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	having many episodes of "not feeling well" and needing the psychological assurances of her carers. She had no involvement with her care planning.	it was unclear how much these upset her. The Panel agreed that Ms [redacted] did require reassurance but appeared to respond to this.
Communication	**High** My Mother was unable to reliably communicate her needs, relying heavily on her carers to anticipate her needs. In "conversation" she had profound word finding difficulties. She would not initiate any form of conversation, relying on others to talk to her.	**High** Ms [redacted] struggled to communicate her needs and her verbal communication was noted to be confused and muddled. Her severe cognitive impairment also made it difficult for her to understand and communicate her needs. The Panel agreed that Ms [redacted] required all her needs to be anticipated as her verbal communication was unreliable. Her eyesight was also noted to be poor and she did not wear her glasses much of the time.

Mobility	**Severe** My mother was not able to bear her own weight and spent her days in a wheelchair, carers re-positioning her on a regular basis as she seemed to find a wheelchair uncomfortable, moving forward a lot or leaning towards the left or right. Transfer to her bed and to> the toilet was with a 2 carer hoist assist (on occasion 3 carers) often crying out during transfer as she had a fear of falling and needed to be regularly comforted. Because she had painful flexion deformity in her knees, this pain also added to her discomfort during transfers. Special cushions were purchased for her wheelchair and the hoist sling to minimise pain. Because of general immobility she needed to be turned regularly in bed to minimise pressure areas and soreness although from 4/9/1998 - 1/1/2001, there are 44 recorded episodes of soreness and skin irritation (groin, buttocks, shoulders hips) requiring application of skin creams. She required assistance to dress, her co-ordination was very poor. General injury risk of falling out of bed or out of her wheelchair. She had no understanding of her limitations and was unable to retain advice, co-operative or comply with instructions so this manifest unpredictability made it difficult for carers. Her bed was fitted with rails and a lap strap was used on her wheelchair but even so, there were unavoidable	**High** The Panel noted that Ms [redacted] was unable to weight bear and was bed or chair bound. She required a hoist and two carers for transfers and at times required three carers. While the falls risk assessment indicated a medium risk of falls, Ms [redacted] required a lap strap to stop her falling when in a wheelchair and tended to fiddle with this increasing the potential for her to fall. Ms [redacted] had also suffered a number of falls during the appeal period. Ms [redacted] suffered with flexion deformity of her knees and was unable to straighten them making it difficult for her to lie in certain positions. However, there was no indication that it had been impossible to move her, as might have been the case with a spinal injury where there was a serious risk of harm on movement. Ms [redacted] required careful positioning and there was the potential for her to suffer some pain or discomfort if she was not carefully positioned.

Domain	Claimant's comment	IRP comment
	instances of injury.	
Nutrition - food and drink	**Low** On the initial admittance summary at Sidegate Lane, it states that my mother needs her food cut up, she has no idea what to do with a knife and fork so feeds herself with a spoon. She needed monitoring to ensure that she didn't put an excess of food in her mouth without swallowing. She was assessed by Dr Raj in December 1998 as having a choking risk. From 4/9/1998 - 1/1/2001, the daily record finds that she put too much food in her mouth causing her to vomit on 18 occasions.	**Moderate** Ms [redacted] required assistance and prompting with eating and often required feeding. She had a tendency to put too much food in her mouth making it difficult for her to swallow which put her at risk of vomiting and choking and Mr [redacted] had indicated that there were 18 incidences around this between 1998 and 2001. Care staff were required to prompt her to swallow and monitor her for signs of choking and it could take a long time for her to finish a meal. The Panel noted that nearer the end of the period Ms [redacted] suffered some weight loss and required supplements. She also had some dental work carried out but this did not appear to impact on her ability to eat. It was unclear whether she had a pureed diet but did require soft food.
Continence	**High** Doubly incontinent, changed regularly both day and night. During 1999 she had bowel movement problems resulting in regular visits from either a district nurse or doctor as detailed in the daily record sheets to administer enemas.	**Moderate** Ms [redacted] was doubly incontinent. She was prone to constipation requiring enemas on a regular basis in 1998/99 but the frequency appeared to reduce after this. Ms [redacted] had a history of cancer of the colon and the Panel noted that there did not appear to have been any needs arising from this during the appeal period. There had been episodes of vomiting at night and it was unclear if she was suffering with an obstruction caused by constipation at these times. The Panel agreed that while Ms [redacted] had required enemas, overall her continence needs were not felt to be problematic as would have been the case with blockages of a catheter where timely and skilled intervention was required.

Skin (including tissue viability)	**Moderate** There are 44 recorded episodes of soreness and skin irritation (groin, buttocks, shoulders hips) in the daily record requiring application of skin creams etc. plus some nightime requirements over the period 4/4/1998-1/1/2001. It would appear that my mother had serious skin irritation problems that she would constantly scratch at night. The itching was a major issue not very well under control. In 2002, there were	**Moderate** The Panel agreed that Ms [redacted] was at high risk of skin breakdown and while she had not suffered with any actual pressure ulcers, her skin was prone to blistering and also became itchy. Ms [redacted] required preventative measures to reduce the risk of pressure damage including application of cream. The Panel could find no indication that any specialist dressings had been required during this period.

Domain	Claimant's comment	IRP comment
	330 doses of Chlorophenramine given. Also in 2002 there were 146 records of skin cream application and 4 records of blistered skin.	
Breathing	**No Needs**	**No Needs** The Panel noted that Ms [redacted] suffered a chest infection in February 2000 but there was no indication of ongoing shortness of breath requiring inhalers or nebulisers.
Drug therapies and medication	**Moderate** During the period 25/9/98-1/1/2000, there are 9 recorded doctor visits and 30 district nurse visits for a variety of problems, eg eye disorders, blisters, bleeding teeth, constipation etc. Pain relief was given on a regular basis. From December 2001-October 2002, 220 Chlorophramine tablets were given, 879 Cocodamol tablets' 340 doses of Sphagula, 670 doses Lactulose and 300 doses of Senna.	**Moderate** Due to her poor cognition Ms [redacted] required administration of her medication as she had no understanding of what medication she was taking and why, making her non-concordant with her drug regime. The Panel agreed that her drug regime was routine in nature with medication being given for pain relief, her bowels and itching. She required care staff to monitor her for potential side effects of her medication and for signs that she was in pain. The Panel noted that there had been the need for skilled input in relation to her drug regime a few days prior to her death when morphine was prescribed via a syringe driver. The Panel also noted that Ms [redacted] had been on antipsychotic medication in the past which had required a level of skill to administer. However this had been stopped about the time of Ms [redacted] admission to the care home.
Seizures/altered states of consciousness	**No needs**	**No Needs** The Panel could find no indication that Ms [redacted] suffered with any seizures or altered states of consciousness.

Other significant care needs		**No Needs** The Panel could find no indication of any other needs.