Good Example of a Decision Support Tool with a Primary Health Needs Test

Decision Support Tool for NHS Continuing Healthcare
Section 1 – Personal Details

Date of completion of Decision Support Tool to reflect claim period retrospectively for 27.02.2012 to 12.11.2012 (Excluding hospitalisation 10.03.2012 to 26.03.2012)

Name		**D.O.B.**	

NHS number and GP/Practice:	

Permanent Address and Telephone Number	**Current Residence (if not permanent address)**

Gender:

Please ensure that the equality monitoring form at the end of the DST is completed

Was the individual involved in the completion of the DST? ~~Yes~~/No (please delete as appropriate)

Was the individual offered the opportunity to have a representative such as a family member or other advocate present when the DST was completed? Yes/No (please delete as appropriate) This DST report was carried out reviewing relevant documentation for a NHS Continuing Care Retrospective Review. A NHS Retrospective Review Claimant Questionnaire was taken into consideration.

If yes, did the representative attend the completion of the DST? ~~Yes~~/No (please delete as appropriate)

Please give the contact details of the representative (name, address and telephone number)

A NHS Continuing Care Claimant Questionnaire was completed (next of kin) on [redacted]

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Summary

Summary pen portrait of the individual's situation, relevant history and current needs, including clinical summary and identified significant risks, drawn from the multidisciplinary assessment:

[redacted] was a qualified electrical engineer. [redacted] was initially employed as an electrical engineer and subsequently as an editor for financial and engineering magazines. [redacted] lived in London before moving to Norfolk in 1991.

In 2004 [redacted] was diagnosed with Multiple System Atrophy (MSA), a progressive neurological disorder. Prior to this diagnosis [redacted] was thought to have Parkinson's Disease but a diagnosis of MSA was subsequently made. [redacted] was regularly reviewed by a Neurologist and supported by a Neurology Specialist Nurse. Symptoms of MSA reflect the three different areas of the brain – basal ganglia causing problems with movement, cerebellum causing poor balance and coordination and the brain stem causing autonomic problems such as poor bladder and blood pressure control.

[redacted] lived at home with [redacted] wife who was [redacted] main carer. [redacted] had further support from carers from [redacted] Care Agency. The carers visited [redacted] three times a day to deliver personal care such as hygiene needs, transfer, prepare a meal, get into bed at night.

On 04.01.2012 [redacted] was admitted to the [redacted] Hospital with a fractured right neck of femur. Following treatment for the fractured neck of femur [redacted] was discharged on 23.01.2012 to [redacted] Ward, [redacted] Hospital for rehabilitation.

Following a period of rehabilitation at [redacted] Hospital [redacted] was discharged back to [redacted] home on 27.02.2012.

On 10.03.2012 [redacted] was admitted to [redacted] Hospital with pneumonia. [redacted] was discharged back to [redacted] home on 26.03.2012.

Past Medical History
Multiple System Atrophy (MSA) - progressive neurological disorder (2004)
Parkinson's Disease (2003) – symptoms later transpired to be MSA and not Parkinson's
Meniere Syndrome (1971)
History of urinary tract infections (UTIs)
Fractured right neck of femur (January 2012)

Individual's view of their care needs and whether they consider that the multidisciplinary assessment accurately reflects these:

Not applicable

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Please note below whether and how the individual (or their representative) contributed to the assessment of their needs. If they were not involved, please record whether they were not invited or whether they declined to participate.

The NHS Continuing Care Retrospective Review was carried out with the knowledge and permission of the patient and next of kin. [redacted] had difficulty writing therefore was unable to sign any relevant consent forms or the fill in the Claimant Questionnaire. [redacted] and next of kin signed or completed any relevant forms on behalf of [redacted].

A NHS Continuing Care Retrospective Review Claimant Questionnaire was completed by the next of kin on 29.01.2013.

Please list the assessments and other key evidence that were taken into account in completing the DST, including the dates of the assessments:

The following documentation was reviewed for the NHS Continuing Care Retrospective Assessment Review:

- NHS Continuing Care Checklist completed on 27.02.2014
- GP Records
- Hospital Records - [redacted] Hospital
- Hospital Records – [redacted] Hospital
- [redacted] Care Agency - carer records
- NHS Retrospective Review Claimant Questionnaire – completed by next of kin on 29.01.2013

A NHS Continuing Care Checklist was completed on 27.02.2014 which indicated the need for a full assessment for the period January 2012 to October 2012.

[redacted] was an inpatient in [redacted] Hospital from 04.01.2012 to 23.01.2012. Following treatment for the fractured neck of femur [redacted] was discharged on 23.01.2012 to [redacted] Ward, [redacted] Hospital for rehabilitation.

Following a period of rehabilitation at [redacted] Hospital [redacted] was discharged back to [redacted] home on 27.02.2012.

On 10.03.2012 [redacted] was admitted to [redacted] Hospital with pneumonia. [redacted] was discharged back to [redacted] home on 26.03.2012.

[redacted] was receiving NHS care while an inpatient at [redacted] Hospital, [redacted] Hospital and [redacted] Hospital. Therefore the periods of hospitalisation would not be considered for NHS Continuing Care for the following periods - 04.01.2012 to 26.01.2012 and 10.03.2012 to 25.03.2102. (The day of discharge back to home from [redacted] Hospital on 27.02.2012 and discharge from [redacted] Hospital on 26.03.2012 would be considered for NHS Continuing Care).

Decision Support Tool for NHS Continuing Healthcare
Section 1 – Personal Details

Assessors' (including MDT members) name/address/contact details noting lead coordinator:

Name
CHC Retrospective Team
[redacted]

Contact details of GP and other key professionals involved in the care of the individual:

The following professionals were involved in the care of [redacted]

- GP
- District Nursing Team
- Consultant Neurologist
- Neurology Specialist Nurse
- Podiatrist
- Speech and Language Therapist
- Physiotherapist
- Occupational Therapist
- Wheelchair Technician
- Carers from [redacted] Care Agency

Decision Support Tool for NHS Continuing Healthcare
Section 2 – Care Domains

Please refer to the user notes

1. Behaviour: Human behaviour is complex, hard to categorise, and may be difficult to manage. Challenging behaviour in this domain includes but is not limited to:

- aggression, violence or passive non-aggressive behaviour
- severe disinhibition
- intractable noisiness or restlessness
- resistance to necessary care and treatment (this may therefore include non-concordance and non-compliance, but see note below)
- severe fluctuations in mental state
- extreme frustration associated with communication difficulties
- inappropriate interference with others
- identified high risk of suicide

The assessment of needs of an individual with serious behavioural issues should include specific consideration of the risk(s) **to themselves, others or property** with particular attention to aggression, self-harm and self-neglect and any other behaviour(s), irrespective of their living environment.

1. Describe the actual needs of the individual, including any episodic needs. Provide the evidence that informs the decision overleaf on which level is appropriate, such as the times and situations when the behaviour to likely to be performed across a range of typical daily routines and the frequency, duration and impact of the behaviour.
2. Note any overlap with other domains.
3. Circle the assessed level overleaf.

[redacted] was usually compliant with care. There were occasions when advice was not followed. For example [redacted] was advised to have a hospital bed by the Occupational Therapist, however this was initially refused but a hospital bed was agreed to at a later date. Although [redacted] did not always comply to advice this was [redacted] decision and [redacted] expressed [redacted] choice.

Frustration with the symptoms of [redacted] condition appeared to be a concern. [redacted] could sometimes become frustrated due to communication difficulties. [redacted] speech could be quiet making it difficult for some people to hear or understand. [redacted] found it difficult to communicate by telephone. The Speech and Language Therapist trialled an Echovoice with [redacted] which enables speech to be heard more clearly. However, [redacted] found this intrusive and found it difficult to use because [redacted] got the wires mixed up. In addition [redacted] felt the headset did not fit properly. [redacted] did not think it worth continuing with the Echovoice.

When [redacted] was delivered an electric wheelchair there was frustration at not being able to use it as [redacted] kept bumping into furniture.

On reviewing the documentation there was no evidence of aggressive behaviour.

Decision Support Tool for NHS Continuing Healthcare
Section 2 – Care Domains
Please refer to the user notes

1. Behaviour

Description	Level of need
No evidence of 'challenging' behaviour.	No needs
Some incidents of 'challenging' behaviour. A risk assessment indicates that the behaviour does not pose a risk to self, others or property or a barrier to intervention. The person is compliant with all aspects of their care.	Low
'Challenging' behaviour that follows a predictable pattern. The risk assessment indicates a pattern of behaviour that can be managed by skilled carers or care workers who are able to maintain a level of behaviour that does not pose a risk to self, others or property. The person is nearly always compliant with care.	**Moderate**
'Challenging' behaviour that poses a predictable risk to self, others or property. The risk assessment indicates that planned interventions are effective in minimising but not always eliminating risks. Compliance is variable but usually responsive to planned interventions.	High
'Challenging' behaviour of severity and/or frequency that poses a significant risk to self, others or property. The risk assessment identifies that the behaviour(s) require(s) a prompt and skilled response that might be outside the range of planned interventions.	Severe
'Challenging' behaviour of a severity and/or frequency and/or unpredictability that presents an immediate and serious risk to self, others or property. The risks are so serious that they require access to an immediate and skilled response at all times for safe care.	Priority

Decision Support Tool for NHS Continuing Healthcare
Section 2 – Care Domains

Please refer to the user notes

2. Cognition: This may apply to, but is not limited to, individuals with learning disability and/or acquired and degenerative disorders. Where cognitive impairment is identified in the assessment of need, active consideration should be given to referral to an appropriate specialist if one is not already involved. A key consideration in determining the level of need under this domain is making a professional judgement about the degree of risk to the individual.

Please refer to the National Framework guidance about the need to apply the principles of the Mental Capacity Act in every case where there is a question about a person's capacity. The principles of the Act should also be applied to all considerations of the individual's ability to make decisions and choices.

1. Describe the actual needs of the individual (including episodic and fluctuating needs), providing the evidence that informs the decision overleaf on which level is appropriate, including the frequency and intensity of need, unpredictability, deterioration and any instability.
2. Where cognitive impairment has an impact on behaviour, take this into account in the behaviour domain, so that the interaction between the two domains is clear.
3. Circle the assessed level overleaf.

[redacted] had MSA a progressive neurological condition.

[redacted] was able to make decisions about his care. [redacted] was unable to write and relied on [redacted] to sign any necessary forms for [redacted] also dealt with [redacted] finances for which [redacted] had an Enduring Power of Attorney. [redacted] was responsible for administering [redacted] medication.

As a result of the progressive MSA [redacted] would sometimes have periods of confusion or become forgetful. [redacted] would sometimes become anxious which at times may have impacted on [redacted] cognition.

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Section 2 – Care Domains
Please refer to the user notes

2. Cognition

Description	Level of need
No evidence of impairment, confusion or disorientation.	No needs
Cognitive impairment which requires some supervision, prompting or assistance with more complex activities of daily living, such as finance and medication, but awareness of basic risks that affect their safety is evident. **OR** Occasional difficulty with memory and decisions/choices requiring support, prompting or assistance. However, the individual has insight into their impairment.	Low
Cognitive impairment (which may include some memory issues) that requires some supervision, prompting and/or assistance with basic care needs and daily living activities. Some awareness of needs and basic risks is evident. The individual is usually able to make choices appropriate to needs with assistance. However, the individual has limited ability even with supervision, prompting or assistance to make decisions about some aspects of their lives, which consequently puts them at some risk of harm, neglect or health deterioration.	Moderate
Cognitive impairment that could include frequent short-term memory issues and maybe disorientation to time and place. The individual has awareness of only a limited range of needs and basic risks. Although they may be able to make some choices appropriate to need on a limited range of issues they are unable to consistently do so on most issues, even with supervision, prompting or assistance. The individual finds it difficult even with supervision, prompting or assistance to make decisions about key aspects of their lives, which consequently puts them at high risk of harm, neglect or health deterioration.	High
Cognitive impairment that may, for example, include, marked short-term memory issues, problems with long-term memory or severe disorientation to time, place or person. The individual is unable to assess basic risks even with supervision, prompting or assistance, and is dependent on others to anticipate their basic needs and to protect them from harm, neglect or health deterioration.	Severe

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Section 2 – Care Domains

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3. Psychological and Emotional Needs: There should be evidence of considering psychological needs and their impact on the individual's health and well-being, irrespective of their underlying condition. Use this domain to record the individual's psychological and emotional needs and how they contribute to the overall care needs, noting the underlying causes. Where the individual is unable to express their psychological/emotional needs (even with appropriate support) due to the nature of their overall needs (which may include cognitive impairment), this should be recorded and a professional judgement made based on the overall evidence and knowledge of the individual.

1. Describe the actual needs of the individual, providing the evidence that informs the decision overleaf on which level is appropriate, including the frequency and intensity of need, unpredictability, deterioration and any instability.
2. Circle the assessed level overleaf.

[redacted] had MSA which is a progressive neurological condition. [redacted] had worked as a electrical engineer and an editor for financial and engineering magazines. The progression of the MSA and deterioration following two admissions to hospital would have impacted emotionally on [redacted] and [redacted]. [redacted] would get anxious. Some of the anxiety may have been due to the impact the progression of the MSA and the impact on [redacted] decreasing independence and reliance on [redacted] and carers. [redacted] bed was in the dining room because [redacted] was unable to get up or down the stairs safely.

In January 2012 [redacted] was admitted to hospital for a fractured neck of femur and in March 2012 for pneumonia. Post discharge from hospital deterioration in [redacted] abilities was having an impact on [redacted] activities of daily living. [redacted] wanted to be independent but had to depend on [redacted] and carers for aspects such as hygiene needs, support and observation of feeding and toileting needs.

When [redacted] was discharged from hospital in February 2012 following treatment for a fractured neck of femur a deterioration in [redacted] mobility had been noted. [redacted] was initially isolated at home because a ramp had not been built to enable [redacted] to get out in [redacted] wheelchair. The ramp was eventually built. [redacted] trialled an electrical wheelchair as [redacted] was unable to move around in a manual wheelchair by [redacted]. The trial was not successful due to [redacted] poor coordination as he kept bumping into furniture. This was frustrating for [redacted] as the electric wheelchair would have allowed some independence. [redacted] continued with the manual wheelchair having to rely on other people to wheel [redacted] about.

[redacted] was spending long periods in bed. This was detrimental to [redacted] psychological and emotional wellbeing.

[redacted] sometimes had difficulty in making [redacted] understood to other people due to quiet speech. [redacted] also found it difficult to use the telephone because people could not hear or understand what

[redacted] was saying. This could lead to frustration.

The Neurologist had suggested the insertion of Percutaneous endoscopic gastrostomy (PEG) for feeding which [redacted] did not want at that time. This further demonstrates the progressive nature of MSA and the decisions that [redacted] was faced with.

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Section 2 – Care Domains
Please refer to the user notes

3. Psychological and Emotional Needs

Description	Level of need
Psychological and emotional needs are not having an impact on their health and well-being.	No needs
Mood disturbance, hallucinations or anxiety symptoms, or periods of distress, which are having an impact on their health and/or well-being but respond to prompts and reassurance. **OR** Requires prompts to motivate self towards activity and to engage them in care planning, support, and/or daily activities.	**Low**
Mood disturbance, hallucinations or anxiety symptoms, or periods of distress, which do not readily respond to prompts and reassurance and have an increasing impact on the individual's health and/or well-being. **OR** Due to their psychological or emotional state the individual has withdrawn from most attempts to engage them in care planning, support and/or daily activities.	Moderate
Mood disturbance, hallucinations or anxiety symptoms, or periods of distress, that have a severe impact on the individual's health and/or well-being. **OR** Due to their psychological or emotional state the individual has withdrawn from any attempts to engage them in care planning, support and/or daily activities.	High

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4. Communication: This section relates to difficulties with expression and understanding, in particular with regard to communicating needs. An individual's ability or otherwise to communicate their needs may well have an impact both on the overall assessment and on the provision of care. Consideration should always be given to whether the individual requires assistance with communication, for example through an interpreter, use of pictures, sign language, use of Braille, hearing aids, or other communication technology.

1. Describe the actual needs of the individual, providing the evidence that informs the decision overleaf on which level is appropriate, including the frequency and intensity of need, unpredictability, deterioration and any instability.
2. Circle the assessed level overleaf.

[redacted] was deaf, completely deaf in [redacted] right ear and wore a hearing aid in his left ear (the deafness was caused by Meniere's disease).

[redacted] had dysphonia and dysarthria due to MSA. [redacted] speech was sometimes weak, quiet and difficult to understand. [redacted] was sometimes slow to make sentences. [redacted] was regularly assessed by the Speech and Language Therapist. Assessment found [redacted] to have a fast rate of speech and reduced lip movement. Strategies were advised including to swallow excess saliva and take a deep breath before speaking, pause for breath often, ensuring a good position for breath support, reducing background noise and distractions, exaggerate articulation and to speak at slow rate. Strategies for individuals communicating with [redacted] included making sure to stand on [redacted] left side, speaking clearly and slowly and ensuring able to see [redacted] mouth. A further strategy included [redacted] giving feedback on what [redacted] understood when asking for repetition. [redacted] found it difficult with some of the strategies. For example [redacted] found it hard to remember to over articulate. [redacted] tried abdominal breathing exercises a few times.

The Speech and Language Therapist trialled an Echovoice with [redacted] The Echovoice would enable speech to be amplified at times when speech was poor. However, despite the Echovoice being effective at amplifying voice, [redacted] found it intrusive. [redacted] agreed to trial the Echovoice for a month but found it difficult to use because [redacted] got the wires mixed up. In addition [redacted] felt the headset did not fit properly. [redacted] did not think it was worth continuing with the Echovoice.

Due to the MSA [redacted] had poor coordination. [redacted] was unable to write therefore had to rely on [redacted] to sign forms or write letters on [redacted] behalf. [redacted] was able at times to use a laptop computer.

[redacted] found it difficult to use the telephone. [redacted] was hard of hearing and despite wearing a hearing aid in [redacted] left ear there was some difficulty in hearing people talk on the telephone. Due to [redacted] speech problems people found it difficult if talking to [redacted] on the telephone to understand what [redacted] was saying.

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4. Communication

Description	Level of need
Able to communicate clearly, verbally or non-verbally. Has a good understanding of their primary language. May require translation if English is not their first language.	No needs
Needs assistance to communicate their needs. Special effort may be needed to ensure accurate interpretation of needs or additional support may be needed either visually, through touch or with hearing.	**Low**
Communication about needs is difficult to understand or interpret or the individual is sometimes unable to reliably communicate, even when assisted. Carers or care workers may be able to anticipate needs through non-verbal signs due to familiarity with the individual.	Moderate
Unable to reliably communicate their needs at any time and in any way, even when all practicable steps to assist them have been taken. The person has to have most of their needs anticipated because of their inability to communicate them.	High

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Please refer to the user notes

5. Mobility: This section considers individuals with impaired mobility. Please take other mobility issues such as wanderinginto account in the behaviour domain where relevant. Where mobility problems are indicated, an up-to-date Moving and Handling and Falls Risk Assessment should exist or have been undertaken as part of the assessment process (in line with section 6.14 of the National Service Framework for Older People, 2001), and the impact and likelihood of any risk factors considered. It is important to note that the use of the word 'high' in any particular falls risk assessment tool does not necessarily equate to a high level need in this domain.

1. Describe the actual needs of the individual, providing the evidence that informs the decision overleaf on which level is appropriate, with reference to movement and handling and falls risk assessments where relevant. Describe the frequency and intensity of need, unpredictability, deterioration and any instability.
2. Circle the assessed level overleaf.

In January 2012 [redacted] was admitted to hospital with a fractured neck of right femur as a result of sustaining a fall. [redacted] was discharged from [redacted] Hospital for a period of rehabilitation at [redacted] Hospital.

Prior to the fractured neck of femur [redacted] was able to mobilise with assistance. However, on return to [redacted] home following rehabilitation at [redacted] hospital [redacted] mobility had deteriorated. Subsequently [redacted] was admitted to [redacted] Hospital with pneumonia and on discharge [redacted] mobility had deteriorated. A district nurse visiting [redacted] noted that [redacted] appeared to have reduced body strength.

[redacted] had MSA in which [redacted] presented with parkinsonism symptoms including poor balance and coordination and poor movement which impacted on his overall mobility. [redacted] was at risk of falls. A neurology review identified that [redacted] was unable to walk because of unequal leg length.

[redacted] had [redacted] bed in the dining room, [redacted] was unable to mobilise safely up or downstairs. On discharge from hospital [redacted] had been spending long periods in bed. This would have impacted on [redacted] psychological and emotional needs and put [redacted] at risk of developing pressure ulcers.

Carers who visited [redacted] three times a day and [redacted] had to transfer using a stand aid hoist or a Ross turntable.

[redacted] was assessed at home by an Occupational Therapist and physiotherapist. The physiotherapist worked with [redacted] and [redacted] to enable safe transfer using a Ross turntable. [redacted] gradually managed to stand [redacted] for longer periods using the turntable. The physiotherapist assessed [redacted] as being safe to be transferred using the Ross turntable. However, carers would not do so until they received written assurance from the physiotherapist. Which was subsequently supplied.

[redacted] used a manual wheelchair but [redacted] was unable to manoeuvre [redacted] around in the

wheelchair. [redacted] had an assessment by a wheelchair technician. As a result of the assessment an electric wheelchair was ordered. Unfortunately [redacted] was unable to use the wheelchair safely due to [redacted] lack of coordination. [redacted] kept bumping into furniture which was frustrating for [redacted]. [redacted] stopped using the electric wheelchair and preferred the use of the manual wheelchair. The wheelchair technician suggested the use of a battery pack for use with the wheelchair so that [redacted] would find it easier to manoeuvre when out. On initial discharge from [redacted] hospital [redacted] was confined to the house because there was no ramp for the wheelchair. A ramp was eventually built to enable [redacted] to get out of the house in the wheelchair.

In addition to lack of mobility as a result of the MSA [redacted] experienced poor posture and would often lean to one side. This required careful positioning in [redacted] chair or bed to ensure [redacted] was supported and comfortable. [redacted] was unable to do this [redacted] and was dependent on [redacted] or carers. The physiotherapist assessed [redacted] for aids to support his posture. A foam wedge proved to be unreliable not offering much support. Cushions were found to be more appropriate. [redacted] was unable to position the cushions [redacted] and relied on the carers or [redacted] to do so.

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Section 2 – Care Domains
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5. Mobility

Description	Level of need
Independently mobile	No needs
Able to weight bear but needs some assistance and/or requires mobility equipment for daily living.	Low
Not able to consistently weight bear. **OR** Completely unable to weight bear but is able to assist or cooperate with transfers and/or repositioning. **OR** In one position (bed or chair) for the majority of time but is able to cooperate and assist carers or care workers. **OR** At moderate risk of falls (as evidenced in a falls history or risk assessment)	Moderate
Completely unable to weight bear and is unable to assist or cooperate with transfers and/or repositioning. **OR** **Due to risk of physical harm or loss of muscle tone or pain on movement needs careful positioning and is unable to cooperate.** **OR** **At a high risk of falls (as evidenced in a falls history and risk assessment).** **OR** Involuntary spasms or contractures placing the individual or others at risk.	**High**
Completely immobile and/or clinical condition such that, in either case, on movement or transfer there is a high risk of serious physical harm and where the positioning is critical.	Severe

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Section 2 – Care Domains
Please refer to the user notes

6. Nutrition – Food and Drink: Individuals at risk of malnutrition, dehydration and/or aspiration should either have an existing assessment of these needs or have had one carried out as part of the assessment process with any management and risk factors supported by a management plan. Where an individual has significant weight loss or gain, professional judgement should be used to consider what the trajectory of weight loss or gain is telling us about the individual's nutritional status.

1. Describe the actual needs of the individual, providing the evidence that informs the decision overleaf on which level is appropriate, including the frequency and intensity of need, unpredictability, deterioration and any instability.
2. Circle the assessed level overleaf.

Due to the MSA [redacted] was at risk of aspiration pneumonia due to dysphagia (swallowing difficulties). [redacted] was assessed by the Speech and Language Therapist (SALT). Following a SALT assessment while [redacted] was in hospital, recommendations included one to one supervision for meals to be alert, to be sat upright, supported feeding and use a valve straw when drinking. Food was pureed and [redacted] had normal fluids.

[redacted] was prescribed Glycopyrronium bromide 2mg tabs one twice a day to dry out excessive saliva. Excessive saliva would impact on his speech and swallowing.

[redacted] was assessed by home visits from the SALT and telephone review. An assessment at home by the SALT in April 2012 (following a referral by the Neurology Specialist Nurse) noted that [redacted] swallow was effective but due to recurrent chest infections a videofluroscopy was required to identify risk of silent aspiration. Recommendations included to puree food (fork mashed), normal fluids, encourage slow intake of food one mouthful at a time and to ensure upright to 90 degrees for all food intake. The SALT advised to try red grape juice for saliva control. At a further review by the SALT the advice regarding the grape juice had not been implemented. The SALT advised that if [redacted] was coughing on oral intake or [redacted] chest deteriorated then the SALT was to be contacted as soon as possible.

A review in Neurology clinic had commented on the possibility of [redacted] to be considered for a Percutaneous endoscopic gastrostomy (PEG). [redacted] was not keen on having a PEG.

There was a delay with an appointment for the videofluroscopy. However, in September 2012 following a report from the videofluroscopy the SALT recommended that [redacted] continued with normal fluids taken via a straw, to trial soft/normal diet avoiding foods that [redacted] finds difficult.

Further assessment of [redacted] swallowing by the SALT in October 2012 noted that [redacted] was managing more normal solid food. No clinical signs of aspiration had been reported. Recommendations included to continue on soft/normal diet, normal fluids via a straw, 90 degree angle for all oral intake, to trial bread and salad. The SALT would regularly review [redacted]

[redacted] tended to lean to one side and [redacted] or carers had to ensure that [redacted] was upright for feeding and not leaning to the side.

[redacted] was prescribed nutritional supplements. The district nurse noted that [redacted] ate well and had an above average BMI 25-29.9 and weight loss score 0.5-5kg. However, in October 2012 the SALT noted that [redacted] had mild weight loss with [redacted] weight being 15-16 stone. It was recommended to monitor weight loss (judging by how clothing fits and whether more loose).

Decision Support Tool for NHS Continuing Healthcare
Section 2 – Care Domains
Please refer to the user notes

6. Nutrition – Food and Drink

Description	Level of need
Able to take adequate food and drink by mouth to meet all nutritional requirements.	No needs
Needs supervision, prompting with meals, or may need feeding and/or a special diet. **OR** Able to take food and drink by mouth but requires additional/supplementary feeding.	Low
Needs feeding to ensure adequate intake of food and takes a long time (half an hour or more), including liquidised feed. **OR** Unable to take any food and drink by mouth, but all nutritional requirements are being adequately maintained by artificial means, for example via a non-problematic PEG.	Moderate
Dysphagia requiring skilled intervention to ensure adequate nutrition/hydration and minimise the risk of choking and aspiration to maintain airway. **OR** Subcutaneous fluids that are managed by the individual or specifically trained carers or care workers. **OR** Nutritional status "at risk" and may be associated with unintended, significant weight loss. **OR** Significant weight loss or gain due to identified eating disorder. **OR** Problems relating to a feeding device (for example PEG.) that require skilled assessment and review.	**High**
Unable to take food and drink by mouth. All nutritional requirements taken by artificial means requiring ongoing skilled professional intervention or monitoring over a 24 hour period to ensure nutrition/hydration, for example I.V. fluids. **OR** Unable to take food and drink by mouth, intervention inappropriate or impossible.	Severe

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Section 2 – Care Domains

Please refer to the user notes

7. Continence: Where continence problems are identified, a full continence assessment exists or has been undertaken as part of the assessment process, any underlying conditions identified, and the impact and likelihood of any risk factors evaluated.

1. Describe the actual needs of the individual, providing the evidence that informs the decision overleaf on which level is appropriate, including the frequency and intensity of need, unpredictability, deterioration and any instability.
2. Take into account any aspect of continence care associated with behaviour in the Behaviour domain.
3. Circle the assessed level overleaf.

Due to [redacted] MSA and autonomic problems, this resulted in reduced bladder control. [redacted] was catheterised which was regularly changed by the district nurse. However, the catheter would become blocked requiring bladder washouts. The washouts were carried out by [redacted] [redacted] or the district nurse. There were occasions when the catheter had to be changed earlier than the planned change due to problems with blockage and overflow. The problems of the catheter blockage were unpredictable but required prompt management to prevent any further complications.

[redacted] was prone to urinary tract infections requiring monitoring and referring to the GP as appropriate to ensure timely treatment such as antibiotics.

[redacted] experienced faecal incontinence and constipation. Monitoring and management of the faecal incontinence and constipation was on-going. There is evidence in the documentation of the district nurse having to perform a rectal examination due to [redacted] not having [redacted] bowels open for six days. [redacted] was prescribed Lactulose for constipation.

[redacted] developed blisters on [redacted] thigh which the district nurse queried whether due to a latex allergy from the catheter. The district nurse monitored and reviewed regularly. The blisters eventually healed.

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7. Continence

Description	Level of need
Continent of urine and faeces.	No needs
Continence care is routine on a day-to-day basis; Incontinence of urine managed through, for example, medication, regular toileting, use of penile sheaths, etc. **AND** is able to maintain full control over bowel movements or has a stable stoma, or may have occasional faecal incontinence/constipation.	Low
Continence care is routine but requires monitoring to minimise risks, for example those associated with urinary catheters, double incontinence, chronic urinary tract infections and/or the management of constipation.	Moderate
Continence care is problematic and requires timely and skilled intervention, beyond routine care (for example frequent bladder wash outs, manual evacuations, frequent re-catheterisation).	**High**

Decision Support Tool for NHS Continuing Healthcare
Section 2 – Care Domains

Please refer to the user notes

8. Skin (including tissue viability): Evidence of wounds should derive from a wound assessment chart or tissue viability assessment completed by an appropriate professional. Here, a skin condition is taken to mean any condition which affects or has the potential to affect the integrity of the skin.

1. Describe the actual needs of the individual, providing the evidence that informs the decision overleaf on which level is appropriate, including the frequency and intensity of need, unpredictability, deterioration and any instability.
2. Circle the assessed level overleaf.

[redacted] required full assistance for [redacted] personal and hygiene needs. [redacted] had poor and fluctuating mobility. [redacted] was unable to move [redacted] independently in bed or in [redacted] chair to change [redacted] position. [redacted] tended to lean to one side which could have put pressure on that side if [redacted] was not positioned appropriately. The Waterlow score assessed by the district nurse was 20 very high risk. At a later date the Waterlow score was assessed as 15 high risk.

On discharge from hospital [redacted] had a small broken area 1cm x 2mm to [redacted] inner buttock crease. It was noted to be 100% granular with good surrounding skin. Further reviews by the district nurse evidenced that the broken area was healing. For example at one visit it was noted to be a slight scuff to buttocks and was covered with Tegaderm dressing for protection. A further visit noted that [redacted] had some discoloration on [redacted] buttocks but a dressing was not required.

There were times when [redacted] spent long periods in bed. When [redacted] was not in bed [redacted] would spend long periods in in chair or wheelchair. [redacted] sat out in a recliner chair, there was a risk of slipping and potential for developing pressure ulcers due to friction or sheering. It was difficult for [redacted] to use a pressure relieving cushion due to [redacted] posture and difficulty in positioning. This made **** at risk of developing pressure ulcers. [redacted] was transferred using a stand aid hoist or Ross turntable. The physiotherapist advised [redacted] to stand [redacted] on the Ross turntable, gradually lengthening the time. This would have given some relief, but there was an inevitable risk to developing pressure ulcers due to long periods sitting or lying down. Cavilon cream (Cavilon is a barrier cream) was regularly applied.

[redacted] developed blisters on his thigh requiring assessment, on-going monitoring and dressings being applied by the district nurse. The district nurse considered the blisters could be a latex allergy from the latex catheters. An alternate catheter such as a silicone catheter was advised and tried but [redacted] was concerned that previous use of a silicone catheter caused too much trauma due to how hard it is and caused bladder damage. Use of the latex catheter continued and there was regular monitoring and dressings by the district nurse. The blisters eventually healed but gauze was used to protect the thigh from the catheter.

[redacted] was catheterised which would overflow requiring bed linen and clothes to be changed promptly to prevent pressure ulcers and moisture lesions. In addition [redacted] had occasional faecal incontinence which would require appropriate management.

[redacted] had dry skin which required the application of an emollient by the carers or [redacted]. Support hosiery is worn by [redacted] on a daily basis which requires [redacted] or carers to put on and remove.

[redacted] was regularly visited by the podiatrist and appropriate assessment and treatment given.

Decision Support Tool for NHS Continuing Healthcare
Section 2 – Care Domains
Please refer to the user notes

8. Skin (including tissue viability)

Description	Level of need
No risk of pressure damage or skin condition.	No needs
Risk of skin breakdown which requires preventative intervention once a day or less than daily without which skin integrity would break down. **OR** Evidence of pressure damage and/or pressure ulcer(s) either with 'discolouration of intact skin' or a minor wound. **OR** A skin condition that requires monitoring or reassessment less than daily and that is responding to treatment or does not currently require treatment.	Low
Risk of skin breakdown which requires preventative intervention several times each day, without which skin integrity would break down. **OR** Pressure damage or open wound(s), pressure ulcer(s) with 'partial thickness skin loss involving epidermis and/or dermis', which is responding to treatment. **OR** A skin condition that requires a minimum of daily treatment, or daily monitoring/reassessment to ensure that it is responding to treatment.	**Moderate**
Pressure damage or open wound(s), pressure ulcer(s) with 'partial thickness skin loss involving epidermis and/or dermis', which is not responding to treatment **OR** Pressure damage or open wound(s), pressure ulcer(s) with 'full thickness skin loss involving damage or necrosis to subcutaneous tissue, but not extending to underlying bone, tendon or joint capsule', which is/are responding to treatment. **OR** Specialist dressing regime in place; responding to treatment	High
Open wound(s), pressure ulcer(s) with 'full thickness skin loss involving damage or necrosis to subcutaneous tissue, but not extending to underlying bone, tendon or joint capsule' which are not responding to treatment and require regular monitoring/reassessment. **OR** Open wound(s), pressure ulcer(s) with 'full thickness skin loss with extensive destruction and tissue necrosis extending to underlying bone, tendon or joint capsule' or above **OR** Multiple wounds which are not responding to treatment.	Severe

Decision Support Tool for NHS Continuing Healthcare
Section 2 – Care Domains

Please refer to the user notes

9. Breathing As with all other domains, the breathing domain should be used to record needs rather than the underlying condition that may give rise to the needs For example, an individual may have Chronic Obstructive Pulmonary Disease (COPD), emphysema or recurrent chest infections or another condition giving rise to breathing difficulties, and it is the needs arising from such conditions which should be recorded.

1. Describe below the actual needs of the individual, providing the evidence that informs the decision overleaf on which level is appropriate, including the frequency and intensity of need, unpredictability, deterioration and any instability.
2. Circle the assessed level overleaf.

[redacted] was prone to chest infections and in March 2012 [redacted] was admitted to [redacted] Hospital with pneumonia from which [redacted] made a recovery.

[redacted] had impaired swallowing ability which if not managed appropriately could result in choking and possible aspiration pneumonia. The Speech and Language Therapist had advised on strategies to prevent complications such as one to one support and sitting upright for feeding.

Decision Support Tool for NHS Continuing Healthcare
Section 2 – Care Domains
Please refer to the user notes

9. Breathing

Description	Level of need
Normal breathing, no issues with shortness of breath.	No needs
Shortness of breath which may require the use of inhalers or a nebuliser and has no impact on daily living activities. **OR** **Episodes of breathlessness that readily respond to management and have no impact on daily living activities.**	**Low**
Shortness of breath which may require the use of inhalers or a nebuliser and limit some daily living activities. **OR** Episodes of breathlessness that do not respond to management and limit some daily living activities. **OR** Requires any of the following: • low level oxygen therapy (24%). • room air ventilators via a facial or nasal mask. • other therapeutic appliances to maintain airflow where individual can still spontaneously breathe e.g. CPAP (Continuous Positive Airways Pressure) to manage obstructive apnoea during sleep.. •	Moderate
Is able to breathe independently through a tracheotomy that they can manage themselves, or with the support of carers or care workers. **OR** Breathlessness due to a condition which is not responding to treatment and limits all daily living activities	High
Difficulty in breathing, even through a tracheotomy, which requires suction to maintain airway. **OR** Demonstrates severe breathing difficulties at rest, in spite of maximum medical therapy Or A condition that requires management by a non-invasive device to both stimulate and maintain breathing (bilevel positive airway pressure, or non-invasive ventilation)	Severe
Unable to breathe independently, requires invasive mechanical ventilation.	Priority

Decision Support Tool for NHS Continuing Healthcare
Section 2 – Care Domains

Please refer to the user notes

10. Drug Therapies and Medication: Symptom Control: The individual's experience of how their symptoms are managed and the intensity of those symptoms is an important factor in determining the level of need in this area. Where this affects other aspects of their life, please refer to the other domains, especially the psychological and emotional domain. The location of care will influence who gives the medication. In determining the level of need, it is the knowledge and skill required to manage the clinical need and the interaction of the medication in relation to the need that is the determining factor. In some situations, an individual or their carer will be managing their own medication and this can require a high level of skill. References below to medication being required to be administered by a registered nurse do not include where such administration is purely a registration or practice requirement of the care setting (such as a care home requiring all medication to be administered by a registered nurse).

1. Describe below the actual needs of the individual and provide the evidence that informs the decision overleaf on which level is appropriate, including the frequency and intensity of need, unpredictability, deterioration and any instability.
2. Circle the assessed level overleaf.

All prescribed medication was administered by [redacted]. [redacted] was unable to self medicate due to difficulty with coordination and poor dexterity. Medication was in soluble from due to risk of choking.

[redacted] was prescribed the following medication:

- Glycopyrronium bromide 2mg tabs one twice a day,
- Ensure plus nutrition supplement
- Amantadine 50mg/5ml 2x5ml spoon twice daily
- Lactulose 10-15mls twice daily
- Lansoprazole 30mg once daily
- ABIDEC multivitamin drops
- Cavilon barrier cream

In addition when [redacted] had a urinary tract infection or chest infection antibiotics were prescribed by the GP.

Medication required monitoring and referral to the GP as required for further review. Medication was also reviewed by the Consultant Neurologist.

Decision Support Tool for NHS Continuing Healthcare
Section 2 – Care Domains
Please refer to the user notes

10. Drug Therapies and Medication: Symptom Control

Description	Level of need
Symptoms are managed effectively and without any problems, and medication is not resulting in any unmanageable side-effects.	No needs
Requires supervision/administration of and/or prompting with medication but shows compliance with medication regime. **OR** Mild pain that is predictable and/or is associated with certain activities of daily living. Pain and other symptoms do not have an impact on the provision of care.	Low
Requires the administration of medication (by a registered nurse, carer or care worker) due to: non-concordance or non-compliance, or type of medication (for example insulin), or route of medication (for example PEG,). **OR** Moderate pain which follows a predictable pattern; or other symptoms which are having a moderate effect on other domains or on the provision of care.	Moderate
Requires administration and monitoring of medication regime by a registered nurse, carer or care worker specifically trained for the task because there are risks associated with the potential fluctuation of the medical condition or mental state, or risks regarding the effectiveness of the medication or the potential nature or severity of side-effects. However, with such monitoring the condition is usually non-problematic to manage. **OR** Moderate pain or other symptoms which is/are having a significant effect on other domains or on the provision of care.	High
Requires administration and monitoring of medication regime by a registered nurse, carer or care worker specifically trained for this task because there are risks associated with the potential fluctuation of the medical condition or mental state, or risks regarding the effectiveness of the medication or the potential nature or severity of side-effects. Even with such monitoring the condition is usually problematic to manage. **OR** Severe recurrent or constant pain which is not responding to treatment. **OR** Risk of non-concordance with medication, placing them at risk of relapse.	Severe
Has a drug regime that requires daily monitoring by a registered nurse to ensure effective symptom and pain management associated with a rapidly changing and/or deteriorating condition. **OR** Unremitting and overwhelming pain despite all efforts to control pain effectively.	Priority

Decision Support Tool for NHS Continuing Healthcare
Section 2 – Care Domains

Please refer to the user notes

11. Altered States of Consciousness (ASC): ASCs can include a range of conditions that affect consciousness including Transient Ischemic Attacks (TIAs), Epilepsy and Vasovagal Syncope

1.Describe below the actual needs of the individual providing the evidence that informs the decision overleaf on which level is appropriate (referring to appropriate risk assessments), including the frequency and intensity of need, unpredictability, deterioration and any instability.
2. Circle the assessed level overleaf.

[redacted] had MSA which could lead to autonomic problems such as low blood pressure. [redacted] experienced some dizzy spells. However, it is noted from review of the documentation that [redacted] had no episodes of altered states of consciousness.

Decision Support Tool for NHS Continuing Healthcare
Section 2 – Care Domains
Please refer to the user notes

11. Altered States of Consciousness (ASC)

Description	Level of need
No evidence of altered states of consciousness (ASC).	No needs
History of ASC but it is effectively managed and there is a low risk of harm.	**Low**
Occasional (monthly or less frequently) episodes of ASC that require the supervision of a carer or care worker to minimise the risk of harm.	Moderate
Frequent episodes of ASC that require the supervision of a carer or care worker to minimise the risk of harm. **OR** Occasional ASCs that require skilled intervention to reduce the risk of harm.	High
Coma. **OR** ASC that occur on most days, do not respond to preventative treatment, and result in a severe risk of harm.	Priority

Decision Support Tool for NHS Continuing Healthcare
Section 2 – Care Domains

Please refer to the user notes

12. Other significant care needs to be taken into consideration: There may be circumstances, on a case-by-case basis, where an individual may have particular needs which do not fall into the care domains described above or cannot be adequately reflected in these domains. If the boxes within each domain that give space for explanatory notes are not sufficient to document all needs, it is the responsibility of the assessors to determine and record the extent and type of these needs here. The severity of this need and its impact on the individual need to be weighted, using the professional judgement of the assessors, in a similar way to the other domains. This weighting also needs to be used in the final decision. It is important that the agreed level is consistent with the levels set out in the other domains. The availability of this domain should not be used to inappropriately affect the overall decision on eligibility.

1. Enter below a brief description of the actual needs of the individual, including providing the evidence why the level in the table overleaf has been chosen (referring to appropriate risk assessments), and referring to the frequency and intensity of need, unpredictability, deterioration and any instability.
2. Circle the assessed level overleaf.

Decision Support Tool for NHS Continuing Healthcare
Section 2 – Care Domains
Please refer to the user notes

12: Other significant care needs to be taken into consideration

Description	Level of need
	Low
	Moderate
	High
	Severe

Decision Support Tool for NHS Continuing Healthcare
Section 2 – Care Domains

Please refer to the user notes

Assessed Levels of Need

Care Domain	P	S	H	M	L	N
Behaviour				X		
Cognition					X	
Psychological Needs					X	
Communication					X	
Mobility			X			
Nutrition – Food and Drink			X			
Continence			X			
Skin (including tissue viability)				X		
Breathing					X	
Drug Therapies and Medication			X			
Altered States of Consciousness					X	
Other significant care needs						
Totals			4	2	5	

Name [redacted] D.O.B. [redacted] NHS Number [redacted]

Decision Support Tool for NHS Continuing Healthcare
Section 2 – Care Domains

Please refer to the user notes

Please note below any views of the individual on the completion of the DST that have not been recorded above, including whether they agree with the domain levels selected. Where they disagree, this should be recorded below, including the reasons for their disagreement. Where the individual is represented or supported by a carer or advocate, their understanding of the individual's views should be recorded.

Decision Support Tool for NHS Continuing Healthcare
Section 3 – Recommendation

Please refer to the user notes

Recommendation of the multidisciplinary team filling in the DST

Please give a recommendation on the next page as to whether or not the individual is eligible for NHS continuing healthcare. This should take into account the range and levels of need recorded in the Decision Support Tool and what this tells you about whether the individual has a primary health need. Any disagreement on levels used or areas where needs have been counted against more than one domain should be highlighted here. Reaching a recommendation on whether the individual's primary needs are health needs should include consideration of:

- **Nature:** This describes the particular characteristics of an individual's needs (which can include physical, mental health, or psychological needs), and the type of those needs. This also describes the overall effect of those needs on the individual, including the type ('quality') of interventions required to manage them.
- **Intensity:** This relates to both the extent ('quantity') and severity (degree) of the needs and the support required to meet them, including the need for sustained/ongoing care ('continuity').
- **Complexity:** This is concerned with how the needs present and interact to increase the skill needed to monitor the symptoms, treat the condition(s) and/or anage the care. This can arise with a single condition or can also include the presence of multiple conditions or the interactions between two or more conditions.
- **Unpredictability:** This describes the degree to which needs fluctuate, creating challenges in managing them. It also relates to the level of risk to the person's health if adequate and timely care is not provided. Someone with an unpredictable healthcare need is likely to have either a fluctuating, or unstable or rapidly deteriorating condition.

Each of these characteristics may, in combination or alone, demonstrate a primary health need, because of the quality and/or quantity of care required to meet the individual's needs.

Also please indicate whether needs are expected to change (in terms of deterioration or improvement) before the case is next reviewed. If so, please state why and what needs you think will be different and therefore whether you are recommending that eligibility should be agreed now or that an early review date should be set.

Where there is no eligibility for NHS continuing healthcare and the assessment and care plan, as agreed with the individual, indicates the need for support in a care home setting, the team should indicate whether there is the need for registered nursing care in the care home, giving a clear rationale based on the evidence above.

Decision Support Tool for NHS Continuing Healthcare
Section 3 – Recommendation

Please refer to the user notes

Recommendation on eligibility for NHS continuing healthcare detailing the conclusions on the issues outlined on the previous page:

Nature

In 2004 [redacted] was diagnosed with Multiple System Atrophy (MSA), a progressive neurological disorder. Symptoms of MSA reflect the three different areas of the brain – basal ganglia causing problems with movement, cerebellum causing poor balance and coordination and the brain stem causing autonomic problems such as poor bladder and blood pressure control.

Following a fall in January 2012 [redacted] was admitted to hospital with a fractured neck of femur. Subsequently [redacted] was discharged to a community hospital and had a period of rehabilitation. On discharge back home it was noted that [redacted] condition had deteriorated. [redacted] had a further hospital admission in March 2012 for pneumonia.

[redacted] was regularly assessed by the physiotherapist, Speech and Language Therapist and the District Nurse. [redacted] was regularly reviewed by a Neurologist and supported by a Neurology Specialist Nurse.

[redacted] was the main carer. Further support consisted of carers visiting [redacted] home three times a day to deliver care. [redacted] required support with activities of daily living such as to transfer from bed to chair or wheelchair, hygiene, observation and assistance with feeding, continence care and administration of medication. [redacted] was transferred using a stand aid hoist or Ross turntable. [redacted] was at risk of falls.

[redacted] had an indwelling catheter which was changed by the district nurse. The catheter would often block requiring bladder washouts delivered by [redacted] or the district nurse. There were occasions when [redacted] catheter had to be changed earlier that the planned change date.

[redacted] spent long periods in bed or [redacted] chair or wheelchair and was at risk of developing pressure ulcers. [redacted] sat out in a recliner chair, there was a risk of slipping and potential for developing pressure ulcers due to friction or sheering. It was difficult for [redacted] to use a pressure relieving cushion due to [redacted] posture and difficulty in positioning. On discharge from hospital [redacted] had a small broken area 1cm x 2mm to [redacted] inner buttock which was assessed, treated and monitored by the district nurse. The wound healed, however, at a further visit it was noted that [redacted] had some discoloration on [redacted] buttocks but a dressing was not required. Pressure ulcer risk was reviewed regularly.

[redacted] developed blisters on his thigh requiring assessment, on-going monitoring and dressings being applied by the district nurse. The district nurse considered the blisters could be a latex allergy from the latex catheters. It was advised that alternative catheter considered but [redacted] and [redacted] were reluctant to try an alternative because of previous experience. The blisters eventually healed following intervention and treatment by the district nurse but regular monitoring of the area was on-going.

[redacted] had dysphagia and was at risk of choking and aspiration pneumonia. [redacted] required observation, one to one support and assistance with feeding.

[redacted] would become frustrated and anxious. [redacted] was unable to be fully independent and the deterioration of his condition impacted on his emotional state.

[redacted] was unable to self medicate and medication was administered by [redacted].

Intensity

[redacted] required input and on-going assessment and monitoring from various health professionals. [redacted] was [redacted] main carer and was supported by agency carers visiting three times a day to deliver care and to get up and put to bed. [redacted] as main carer liaised on a regular basis with health professionals to communicate concerns and progress. Prescribed medication was administered by [redacted] and [redacted] would report any concerns regarding effectiveness of the medication.

Following a fall [redacted] had an admission to hospital with a fractured neck of femur and was at risk of further falls. Although [redacted] spent long periods in bed or [redacted] chair there was a risk when being transferred. [redacted] would also slide down his recliner chair which if not regularly observed could result in an injury.

[redacted] was at risk of choking and aspiration pneumonia. Recommendations had been made by the Speech and Language Therapist to ensure [redacted] was able to eat safely and prevent complications. For example he required one to one support at mealtimes.

[redacted] had dysarthria and [redacted] voice often went quiet making it difficult for people to understand what [redacted] was saying. Advice and coping strategies were given by the Speech and Language Therapist some of which were implemented by [redacted]

[redacted] had an indwelling urinary catheter which often became blocked and required frequent bladder washouts which were carried out by [redacted]. On occasions the blockages would be problematic requiring an earlier change in catheter by the district nurse earlier than the planned change date. [redacted] was prone to urinary tract infections which required monitoring and prescribed treatment.

[redacted] was at risk of developing pressure ulcers. [redacted] would often spend long periods in bed. There were other occasions when [redacted] would spend long periods in a chair or wheelchair. [redacted] sat out in a recliner chair and on occasions [redacted] would slip down the chair with a potential for developing pressure ulcers due to friction or sheering. It was difficult for [redacted] to use a pressure relieving cushion due to [redacted] posture and difficulty in positioning.

Complexity

The progressive nature of MSA meant deterioration in [redacted] condition. A Consultant Neurologist, Neurology Specialist Nurse and other health professionals were involved in the care of [redacted]

Symptoms of MSA reflect the three different areas of the brain – basal ganglia causing problems with movement, cerebellum causing poor balance and coordination and the brain stem causing

autonomic problems such as poor bladder and blood pressure control. [redacted] was experiencing symptoms and affected by the three different areas of the brain. For example [redacted] was catheterised due to poor bladder control and [redacted] mobility was limited.

[redacted] MSA resulted in interrelating concerns. For example [redacted] was at risk of developing pressure ulcers. This required on-going monitoring and appropriate management. [redacted] spent long periods in a chair or in bed, [redacted] leaned to one side which made positioning difficult, [redacted] had occasional faecal incontinence and [redacted] catheter would occasionally overflow. These factors required appropriate and prompt management to decrease the risk.

[redacted] was at risk of choking and aspiration pneumonia. In March 2012 [redacted] had an admission to hospital with pneumonia. The Speech and Language Therapist made recommendations to lessen the risk of choking such as one to one support, sitting up at 90 degrees when feeding. [redacted] would lean to one side and appropriate methods of support had to be considered to enable [redacted] to sit more upright. The physiotherapist trialled and advised [redacted] on appropriate support such as cushions.

[redacted] was not a trained nurse but [redacted] was delivering care with the skills that a trained nurse would do. For example carrying out bladder washouts for a blocked catheter. In addition [redacted] was monitoring [redacted] for any concerns or complications and ensuring prompt communication to prevent escalation to more serious complications. For example liaising with the GP or district nurse regarding UTIs to enable prompt treatment to prevent sepsis. [redacted] administered [redacted] [redacted] medication and would monitor for effectiveness and any concerns with escalation to the district nurse or GP as appropriate.

Unpredictability

Due to the symptoms experienced by [redacted] and the progressive deterioration of his condition such as poor mobility and risk of aspiration pneumonia [redacted] care needs could often result in unplanned intervention.

[redacted] had an indwelling catheter. The catheter would often block requiring bladder washouts delivered by [redacted] or the district nurse. There were occasions when the bladder washouts were not successful and [redacted] catheter had to be changed earlier than the planned change date. [redacted] was prone to UTIs requiring monitoring and treatment. The problems with the catheter blocking and UTIs were unpredictable.

[redacted] was at risk of developing pressure ulcers and this required monitoring. On discharge from hospital [redacted] had a small broken area to his inner buttock crease. There were times when [redacted] spent long periods in bed or in [redacted] chair and wheelchair. [redacted] sat out in a recliner chair, there was a risk of slipping and potential for developing pressure ulcers due to friction or sheering. There was an unpredictable risk to developing pressure ulcers due to long periods sitting or lying down.

[redacted] also developed blisters on [redacted] thigh requiring assessment, treatment and on-going monitoring. The district nurse considered this to be a latex allergy and alternative catheters were advised which [redacted] refused due to a difficult previous experience of using a silicone catheter. The blisters healed but there was an unpredictable risk that they would occur again.

[redacted] would regularly liaise with health professionals regarding his condition. Due to the progressive nature of MSA it was difficult to predict when symptoms would deteriorate and require further review or intervention.

Recommendation:
The clinical retrospective assessor has scrutinised all available evidence and considers that the quantity and quality of [redacted] needs in totality are indicative of a primary health need. Therefore considers [redacted] was eligible for NHS Continuing Healthcare retrospectively from 27.02.2012 to 12.11.2012. (Excluding hospitalisation 10.03.2012 to 26.03.2012). From January 2012 [redacted] was in [redacted] Hospital prior to 27.02.2012 therefore would not be considered for NHS Continuing Healthcare until discharge back to his home on 27.02.2012.

From 12.11.2012 [redacted] was found to be eligible for NHS Continuing Healthcare.

Signatures of MDT making above recommendation:

Health professionals

Printed Name	Designation	Professional Qualification	Signature	Date
[redacted]	CHC Retrospective Practitioner	RGN		[redacted]

Social care/other professionals

Printed Name	Designation	Signature	Date