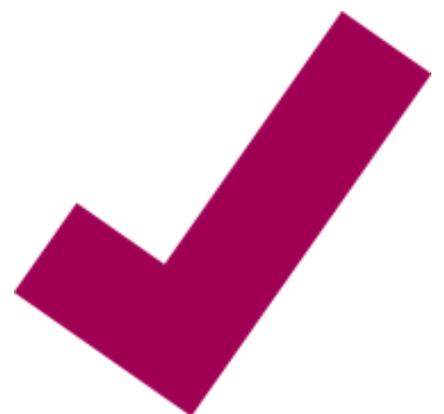


**An independent
investigation into the
care and treatment of
mental health service
users (F and Maureen) in
County Durham**



Author: Nick Moor

First published: September 2017

Niche Health and Social Care Consulting is an independent management consultancy that specialises in supporting health care providers with all issues of safety, governance and quality, including undertaking independent investigations following very serious incidents.

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Niche Health & Social Care Consulting Ltd
Emerson House
Albert Street
Eccles
MANCHESTER
M30 0BG

Telephone: 0161 785 1001
Email: enquiries@nicheconsult.co.uk
Website: <http://www.nicheconsult.co.uk/>

Contents

Impact statement from Kevin Rudland, husband of Maureen. 1

Executive summary 2

1 The incident 10

2 Independent investigation 10

 Approach to the investigation 10

 Structure of the report 12

3 The care and treatment of F and Maureen 13

 About F 13

 Summary of F’s care during this admission 15

 About Maureen 18

 Summary of Maureen’s care during this admission 20

4 Arising issues, comment and analysis – F’s care 25

5 Arising issues, comment and analysis – Maureen’s care 39

6 Internal investigation and action plan 48

 Actions taken since the investigation 50

7 Overall analysis and recommendations 52

 Predictability and preventability 53

 Was the death of Maureen predictable? 54

 Was the death of Maureen preventable? 54

 Table of Recommendations 55

Appendices

Impact statement from Kevin Rudland, husband of Maureen.

All that Maureen and I wanted was for her to come home from Picktree Ward. I had prepared our home to make the house as safe as possible for her return. She had done so well and was on the way home when this dreadful incident happened. We had been married for 23 years and 2 days when she died. I still miss her, and talk to her, every day. I made a bracelet for her after she died. But then I stopped doing things like that because it felt too difficult. After Maureen died, I started drinking too much, and I blamed myself for what had happened. I thought I had done everything possible for her welfare, but when I look back it seems it was all a waste of time. I have only recently started going out, and making jewellery again, more than two years after she died. At times I don't know what to do with myself. I've tried going back to work, but find that really difficult at times. I've not much left to live for now, though I do have my daughter and grand-daughter.

It is very difficult to care for someone with dementia, when you need to do all the tasks to run a home as well. Often, when I asked for help, I was told people would be in touch, but they weren't. Despite what people say, there is very little help for carers of people with dementia. People wonder why carers suffer with stress and breakdowns, it all catches up with you.

Before Maureen was admitted to Picktree ward I was wondering around with a dark cloud over my head. But even when your loved one gets admitted to hospital, it isn't over. Patients in wards get very bored, and need something to do, not just have a member of staff sitting with them reading a news-paper. It's not enough to care, carers and patients need real practical help that makes a difference.

Different parts of the health service need to communicate much better. I did my best to tell everybody about Maureen's health, her chest condition and her little mannerisms, but it seems it went in one ear and out the other. Little things matter, and little things were missed. And sadly it is the little things that matter, and make all the difference.

I can't easily forgive or forget what happened. I'd like to think that lessons can be learned but I hear this all the time, and I'm not sure they will be.

Mr Kevin Rudland.

Executive summary

F and Maureen were patients on Picktree Ward, a mental health service for older people (MHSOP) ward in the Bowes Lyon Unit at Lanchester Road Hospital, County Durham, provided by Tees Esk and Wear Valleys NHS Foundation Trust (TEWV). F was an 87 year old man, who was initially admitted to Ceddesfeld Ward, Auckland Park Hospital on 7 April under Section 2 of the Mental Health Act (1983) (MHA) and then transferred to Picktree Ward on 10 April. He was admitted because the care home where he had been staying were unable to cope with his sudden and unpredictable aggressive behaviour.

Maureen was a 69 year old lady who was an inpatient on Picktree ward, admitted on 17 April under Section 2 MHA. She had been receiving respite care in a care home in Peterlee, and had become unwell, with increasingly challenging and threatening behaviour which became unmanageable in the home.

By the time of the incident, both patients had become more settled, though both were regraded to Section 3 MHA.

Arrangements were being made to plan for Maureen's discharge home. On 19 May 2015 she went on a home assessment with the Occupational Therapist. This had gone well.

After her return, whilst in the seating area outside the ward office Maureen approached F, who was sitting in a chair and demanded he move from 'her seat'. F refused to move and Maureen swiped at his face with her cardigan. The member of staff with her intervened to calm Maureen but as Maureen turned to move away F impulsively jumped from the chair and pushed Maureen from behind.

Maureen was taken to University Hospital North Durham (UHND) and it was confirmed that she had a fractured neck of femur. Following surgery for the fractured neck of femur Maureen remained in the hospital. Her physical health deteriorated and she subsequently died on the 25 May 2015.

About F

At the time of the incident, F was an 87 year old man from the east of County Durham. He had been brought up in a family of nine children. He had been married to his wife for 60 years, and he was regularly visited by his family.

He had always been keen on keeping fit and had ran Judo classes in local schools and clubs. He was described as a gentleman who would never hurt a woman. At the same time he did not like bigger people trying to intimidate him and was quite capable of knocking them down.

F had first presented with cognitive impairment to Mental Health Services for Older People (MHSOP) in 2006. He was then diagnosed with Alzheimer's disease. He was first admitted to Picktree ward in in January 2014, under Section 2 of the MHA, following a deterioration in his mental state when he had become increasingly confused, agitated and aggressive. He was discharged home in February 2014 with

a full package of care from the MHSOP community mental health team and a care coordinator.

In November 2014 F's wife had fallen, and sustained a fractured neck of femur. F attended hospital with her, but became disoriented, agitated and aggressive. He assaulted four members of the A&E staff. He was admitted to Ceddesfeld ward under Section 2 MHA following a mental health act assessment. Following this episode both he and his wife were admitted to Jack Dormand Care home, as they could no longer manage to live independently.

In spring of 2015 he had become increasingly agitated and aggressive again. The community psychiatric nurse (CPN) was asked to urgently assess F, as the care home felt they could no longer manage his unpredictable behaviour. It was reported that F had hit a member of staff, hit a drugs trolley and pulled a radiator off the wall. There was no evidence of aggression during the assessment, but the care home staff reported they were afraid of him.

Based on this assessment a MHA assessment was then completed by an Approved Mental Health Practitioner (AMHP)¹ and two Section 12 doctors.² Because of the escalation in his behaviour, and the difficulties experienced by the care home trying to manage his needs it was agreed F needed detention under Section 2 of the MHA. F was admitted to Ceddesfeld Ward, Auckland Park Hospital at 10.15pm on 7 April 2015, because there were no beds available on Picktree ward at that time.

About Maureen

Maureen was a 69 year old lady who had first had contact with MHSOP in August 2014 after being referred by her GP for assessment of her memory. She also had a history of Chronic Obstructive Pulmonary Disease (COPD) and asthma.

She was first seen by a CPN on 21 August 2014 in the Blackhall clinic, with a recent history of forgetfulness, confusion, irritability and low mood over the last six months. She had scored 16 on the Six Item Cognitive Impairment Test (6CIT).³ This indicated significant cognitive impairment.

At the end of November Maureen was admitted for a chest infection to University Hospital North Tees, which exacerbated her dementia. She was seen shortly after this by the consultant psychiatrist, who gave a likely diagnosis of Alzheimer's Dementia. She was prescribed Pregabalin⁴ for her anxiety and Donepezil⁵ to help

¹ AMHPs are mental health professionals who have been approved by a local social services authority to carry out certain duties under the Mental Health Act. They are responsible for coordinating mental health act assessments and admission to hospital if a patient is sectioned.

² A section 12 approved doctor is a medically qualified doctor who has been recognised under section 12(2) of the Mental Health Act (1983) amended (2007). They have specific expertise in mental disorder and have additionally received training in the application of the Act.

³ The 6CIT is a well validated tool that is used to test orientation in time and place, and short term memory. It is an alternative to the MMSE, and is usually used in primary care. Questions are scored 0 for correct answers. Overall scores above 8 / 28 indicate cognitive impairment.

⁴ Pregabalin can be helpful in treating the symptoms of generalised anxiety disorder.
<http://patient.info/medicine/pregabalin-lyrica>

with symptoms of Alzheimer's, to commence after the antibiotic treatment for her chest infection had been completed.

Initially this had a positive effect, and Maureen was much more settled at home, and her husband was able to care for her.

However by the end of December and into early January 2015 there were further episodes of her husband calling the service saying he could no longer cope, due to a lack of sleep.

Her husband reported in February 2015 that she seemed to be hallucinating more than normal, and there were occasions when she did not recognise her husband. On one occasions she thought he was an intruder and was going to call the police.

A plan was agreed with her husband for Maureen to attend a day service in Peterlee for people with complex dementia, but after further crises, it became necessary to admit Maureen to a care home in Peterlee for emergency respite care on 26 March. An emergency Deprivation of Liberty Safeguards⁶ detention was applied for and accepted.

However, over the following few weeks, Maureen's condition deteriorated further whilst in the care home. There were signs that her chest infection had worsened, but that was not seen as a reason to explain her mental deterioration.

On the 17 April, she was reported to have been attempting to hit other residents, was disinhibited and climbing over furniture. She was described as 'manic' and care staff were struggling to cope. She was seen by her consultant psychiatrist, and a recommendation for detention under Section 2 of the Mental Health Act was made, and Maureen was admitted to Picktree ward on 17 April 2015.

Findings

F's care and treatment

F had received a comprehensive suite of multi-disciplinary assessments. However, not all were signed or completed correctly. We found inconsistencies in the completion of some assessments, with some having not followed the guidelines correctly. For example, the falls risk assessment did not fully consider all aspects of his medical history which were pertinent factors in his risk of falls, such as multiple prescribed medications and a heart condition which could cause fainting attacks. The assessment of his risk of aggression was based on a robust formulation and thorough consideration of the factors that may increase the risk of aggression. He was known to be predictably unpredictable. However, not all the incidents involving F were reported correctly, which potentially downplayed the consideration of his actual risk of aggression.

⁵ Donepezil (known as AChE inhibitors) can be prescribed for people with Alzheimer's disease. <http://www.nhs.uk/Conditions/Alzheimers-disease/Pages/Treatment.aspx>

⁶ The Mental Capacity Act Deprivation of Liberty Safeguards https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/437661/Final_DoLS_Guidance_2015.pdf

When he was on enhanced observations these were not recorded properly according to policy.

Also, although there were care plans to help prevent aggressive incidents, there was no robust plan to guide the management of F once he was involved in an incident. For example, he was known to be able to retaliate very quickly.

Maureen's care and treatment

Like F, Maureen had received a very comprehensive and wide ranging suite of assessments. However we again found gaps in the completion of these, especially some of the more routine assessments such as fluid balance charts and food intake recording. On some occasions, where the assessment indicated a need for intervention, this did not always follow. For example, there were occasions where her Early Warning Score indicated a need to contact medical staff (according to policy), but this did not happen.

The information concerning Maureen's rapid weight loss either does not seem to have been understood or acted upon. There was no care plan to address this rapid weight loss, although staff were monitoring her food intake and actually helping her to gain weight. Further to this, other assessments did not seem to acknowledge the weight loss, or consider the risks this posed to Maureen's health.

Because of this there was no link made from a low BMI to the impact it had on her Waterlow, MUST and FRAX assessments and the potential for increased risk of harm. Consequently there was no mitigation or intervention plan in place for reducing the risk of fracture or increasing Maureen's weight arising from this.

The risk of fracture and osteoporosis assessment known as the FRAX[®] tool⁷ was completed incorrectly. This assessment gave her a score of a 12% probability of major osteoporosis and a 4.6% probability of a hip fracture over the next ten years. This had failed to include her low BMI as a risk factor. When we completed the assessment again we arrived at a higher risk of fracture (14% in ten years) and a 26% probability of major osteoporosis.

Like F, Maureen had a plan of care for her aggression, but also like F, this did not include guidance on how to actually manage an aggressive episode.

The internal investigation

The internal investigation did not consider the care and treatment of F, focussing instead solely on Maureen. We were told this was because there was an

⁷ The FRAX[®] tool has been developed to evaluate fracture risk of patients at the metabolic diseases unit, University of Sheffield. It is based on individual patient models that integrate the risks associated with clinical risk factors as well as bone mineral density (BMD) at the femoral neck.

understanding that NHS England would commission an investigation, but we are not clear why this would make any difference. This is a major omission, and prevented the Trust from learning lessons as quickly as possible to prevent further recurrence of similar incidents.

Even though the internal investigation considered Maureen's care, we have also further identified aspects of Maureen's care that the internal investigation did not. We have discussed earlier the failure to link her low BMI and weight loss to her risk of osteoporosis, and the lack of a care plan to help her gain weight. These aspects were not identified in the internal investigation.

There is a reasonable consideration of some of the findings, and the action plan arising would improve some aspects of care for someone like Maureen, by improving physical health assessment and interventions and also the more accurate recording of EWS.

However we believe that the internal investigation was limited due to the lack of wider consideration of factors relevant to Maureen's care (low BMI and risk of fragility fracture) and the failure to consider F's care in general.

We believe the internal investigation conclusion, that there is no root cause of the death of Maureen, is flawed.

The implementation of actions

The actions identified in the internal investigation report were:

1. All patients to have physical health reviews fortnightly with medical staff or physical health practitioner and this to be recorded in physical health care notes. Physical health review to take place at the point of any issues/ concerns raised by staff.
2. All staff on the MHSOP wards to have EWS competency carried out by the Physical Health Care Nurse Consultant.
3. There have been delays in ambulances attending in-patients within mental health wards. This action is being addressed as a Trust-wide issue with the NEAS / Acute Trust

We have seen good evidence that these actions have been completed. Patients now receive a review and an entry about physical health at least every 2 weeks in the notes. This could include review of blood results, review in MDT, or review in report out or review undertaken by the physical health care practitioner on a regular basis. We have not seen evidence that this is audited and are therefore unable to provide assurance that this action is complete.

All staff on Picktree ward were reported to have been trained to properly use EWS, but now the ward has closed it is harder to evidence. All new starters are told that they have to complete the course.

EWS charts are audited weekly and gaps are addressed at a local level. There is also annual EWS audit done by Physical Healthcare team. We have seen recent audits of the use and completion of EWS for Durham and North Yorkshire. We are assured that the Trust is regularly monitoring the correct use of EWS and taking steps to address any identified deficits.

We are also assured that further training does take place in the use of physical observations, which is delivered through the Trust training department.

The Trust has provided the SBARD (Situation, Background, Assessment, Recommendation and Decision) briefing note in Relation to In-patient requests for an ambulance for a fallen patient with a suspected or actual fractured neck of femur dated 12th April 2016. This details the following actions when calling for an ambulance:

“Report the location of the patient and then immediately inform the controller that we are not an acute trust but are a mental health or learning disability facility.”

The ward staff we spoke with were all able to explain in detail the steps they would now take, and how they would stress to the ambulance despatch team that the ward was not equipped to deal with emergencies and the patient would need to be blue lighted to A&E.

The Trust also provided us with the report from the Executive Director of Nursing to the Executive Management team on “Fractured Neck of Femur/Ambulance Response Times Report and Options Paper” dated 12 October 2016. This paper outlined the background to the problem of delayed response times and increased mortality of patients with fractured neck of femurs. The paper made recommendations that the Trust purchase specialist lifting equipment for patients that had fallen and had a suspected fracture. We have not seen the evidence that the Trust has purchased this equipment.

Because of the information the staff gave us on the actions they would now take and the reports and papers that have been issued within the Trust including reports to executive management team, enhanced guidance on management post fall, and the learning lessons bulletin we are assured that the Trust has dealt with this final action point.

Was the death of Maureen predictable?

In considering this we have asked two key questions:

- Was it reasonable to have expected those caring for F and Maureen to have taken more proactive steps to manage the risks presented by them?
- Did they take reasonable steps to manage these known risks?

We consider that F was known to be predictably unpredictable. When he was placed on EVO there was a notable reduction in incidents, possibly because there were staff on hand to defuse any incidents before they escalated. We believe that it was

premature to take him off EVO. We noted that the incident on 19 May was provoked by Maureen and F retaliated. Even though a member of staff was on hand they were unable to prevent him from pushing Maureen which led to her fall.

Although we believe it was predictable that F would be involved in an altercation with someone, it was not predictable that this would be Maureen, or lead to her death.

Was the death of Maureen preventable?

We have considered the following points:

- F was known to be predictably unpredictable and aggressive, particularly when retaliating;
- Maureen was inadequately assessed for risk of fragility fracture, and mitigation was not put in place soon enough; and
- After her fall, Maureen then spent an inappropriate amount of time lying on the floor whilst waiting for an ambulance. It is known that for people with COPD, lying flat reduces lung function and increases the risk of acquiring a chest infection.

Actions taken which may have lessened the risk of harm arising include:

- 1 More appropriate intervention planning to deal with F's retaliation when provoked (based on previous behaviours) may have prevented the retaliatory pushing over of Maureen;
- 2 Earlier consideration of the risk of Maureen's osteoporosis and treatment of this whilst in the community may have lessened the likelihood of fracture;
- 3 More rigorous assessment on admission for Maureen, with robust physical health interventions, based on accurate history taking and assessment might have improved her physical care; and
- 4 Consideration of her risk of fragility fracture based on accurate assessment of BMI, and possible use of hip protectors may also have prevented Maureen fracturing her neck of femur.

Because of these issues, we believe that the death of Maureen was caused by several contributory factors all coalescing at the same time, and that it was preventable.

Recommendations

We have made nine recommendations to improve practice.

Recommendation 1:

The Trust should assure itself that the findings and observations of patients when admitted to MHSOP wards leads to accurate care planning and appropriate interventions.

Recommendation 2.

The Trust should review management of aggression guidance and the clinical link pathway for Behaviours that Challenge in Mental Health Services for Older People

wards to ensure that explicit guidance in how to manage an incident is an outcome of the assessment process and is included in intervention plans.

Recommendation 3:

The Trust should ensure that MHSOP wards fully comply with the policy on recording observations.

Recommendation 4:

The Trust should ensure that all relevant policies and procedures are updated whenever new guidance from NICE is issued.

Recommendation 5:

The Trust should develop a programme of increased awareness of the need to accurately report incidents with the MHSOP wards, and assure itself that incidents are being accurately reported.

Recommendation 6:

The Trust should assure itself that MHSOP wards are now following its own best practice guidance with regards to Behaviours that Challenge in dementia.

Recommendation 7:

The Trust should assure itself that assessments of risks in elderly patients are completed thoroughly and accurately, incorporating all aspects of relevant medical history, and which then lead to appropriate interventions to mitigate these risks.

Recommendation 8:

NHS Durham Dales Easington & Sedgefield Clinical Commissioning Group and the Trust should work together to ensure that they fully implement the NICE Clinical guideline [CG146], Osteoporosis: assessing the risk of fragility fracture correctly identifying all patients at risk of fragile fracture on respective caseloads.

Recommendation 9:

NHS Durham Dales, Sedgefield and Easington CCG, NHS North Durham CCG, Tees, Esk & Wear Valleys NHS Foundation Trust, County Durham and Darlington NHS Foundation Trust and North East Ambulance Service should regularly and collectively review all deaths of patients transferred from MHSOP wards to A&E with suspected fragility fractures to fully identify opportunities for system improvements to reduce premature deaths.

1 The incident

- 1.1 F and Maureen were patients on Picktree Ward, a mental health service for older people (MHSOP) ward in the Bowes Lyon Unit at Lanchester Road Hospital, County Durham, provided by Tees Esk and Wear Valleys NHS Foundation Trust (TEWV).
- 1.2 F was an 87 year old man, who was initially admitted to Ceddesfeld Ward, Auckland Park Hospital on 7 April 2015 under Section 2 of the Mental Health Act (1983) (MHA) and then transferred to Picktree Ward on 10 April. He was admitted because the care home where he had been staying were unable to cope with his sudden and unpredictable aggressive behaviour.
- 1.3 Maureen was a 69 year old lady who was an inpatient on Picktree ward, admitted on 17 April under Section 2 MHA. She had been receiving respite care in a care home in Peterlee, and had become unwell, with increasingly challenging and threatening behaviour which became unmanageable in the home.
- 1.4 By the time of the incident, both patients had become more settled, though both were regraded to Section 3 MHA.
- 1.5 Arrangements were being made to plan for Maureen's discharge home. On 19 May 2015 she went on a home assessment with the Occupational Therapist. This had gone well.
- 1.6 After her return, whilst in the seating area outside the ward office Maureen approached F, who was sitting in a chair and demanded he move from 'her seat'. F refused to move and Maureen swiped at his face with her cardigan. The member of staff with her intervened to calm Maureen but as Maureen turned to move away F impulsively jumped from the chair and pushed Maureen from behind.
- 1.7 Maureen was taken to University Hospital North Durham (UHND) and it was confirmed that she had a fractured neck of femur. Following surgery for the fractured neck of femur Maureen remained in the hospital. Her physical health deteriorated and she subsequently died on the 25 May 2015.

2 Independent investigation

Approach to the investigation

- 2.1 The independent investigation follows the NHS England Serious Incident Framework⁸ (March 2015) which replaces the previous Department of Health

⁸ NHS England Serious Incident Framework March 2015. <https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incident-framwrk-upd.pdf>

guidance (94) 27⁹ on the discharge of mentally disordered people and their continuing care in the community, and updated paragraphs 33-36 issued in June 2005. The terms of reference for this investigation are given in full in Appendix A.

- 2.2 The main purpose of an independent investigation is to ensure that mental health care related homicides are investigated in such a way that lessons can be learned effectively to prevent recurrence. The investigation process may also identify areas where improvements to services might be required which could help prevent similar incidents occurring.
- 2.3 Most independent investigations review the care provided to the perpetrator up to the point of the incident. In this case, as both the victim and perpetrator were patients of the same service we have reviewed the care provided during that episode of care for them both. We have limited our investigation to the care provided from the admission of both F and Maureen to Picktree ward up to the time of the incident on 19 May, 2015.
- 2.4 The overall aim is to identify common risks and opportunities to improve patient safety, and make recommendations about organisational and system learning.
- 2.5 The investigation was carried out by Nick Moor, Director of Niche. Nick Moor is a former mental health nurse with more than 20 years clinical experience, most of which was in care of older people with mental health problems. He has also been lead investigator or responsible for the delivery of more than 50 serious incident investigations in healthcare.
- 2.6 Expert advice was provided by Andrea Ward, General Manager of the Mental Health Service for Older People, Nottinghamshire Healthcare NHS Foundation Trust. Andrea has worked in elderly care for over thirty years as a clinical practitioner, practice educator and senior manager.
- 2.7 The investigation team will be referred to in the first person plural in the report.
- 2.8 The report was peer reviewed by Carol Rooney, Deputy Director of Niche.
- 2.9 The investigation comprised a review of the clinical notes of F and Maureen, and a range of policy and other documents, with reference to the National Patient Safety Agency (NPSA) guidance.¹⁰
- 2.10 We have met with the key members of staff who were on duty at the time of the incident. These were:
 - consultant psychiatrist / responsible clinician for F

⁹ Department of Health (1994) HSG (94)27: Guidance on the Discharge of Mentally Disordered People and their Continuing Care, amended by Department of Health (2005) - Independent Investigation of Adverse Events in Mental Health Services

¹⁰ National Patient Safety Agency (2008) Independent Investigations of Serious Patient Safety Incidents in Mental Health Services

- Ward manager
 - 2 Staff nurses on duty on 19 May
 - Health care assistant
- 2.11 We have visited Picktree Ward, which is now closed, to gain an understanding of the care environment for F and Maureen.
- 2.12 We have not met with the husband of Maureen. We were told that he had not wanted to engage with the investigation by NHS England. We did not want to cause him any further distress, but we do wish to extend our sincere condolences to him and his family for the death of Maureen.
- 2.13 We have met with the nephew and niece of F, to share our approach and purpose of the investigation, and we have incorporated their views in this investigation. The final report was shared with them once it had been completed and factually correct.
- 2.14 We have been informed that F died during the course of this investigation, and we wish to extend our condolences to his family.
- 2.15 Although F had not been convicted of any offence relating to the death of Maureen, this investigation has been necessary as there are still lessons that can be learned to improve care and treatment of similar older people like F and Maureen.

Structure of the report

- 2.16 Section 4 sets out the details of the care and treatment provided to F and Maureen. We have included a brief chronology of their care during their last admissions in Appendix B in order to provide the context in which they were known to services in Tees Esk and Wear.
- 2.17 Section 5 reviews the care and treatment provided to F and Maureen against the terms of reference and includes comment and analysis.
- 2.18 There are three elements which will be completed once the report is published. These are:
- Support the Trust to develop an outcome based action plan based on investigation findings and recommendations.
 - Support the commissioners (North Durham CCG) to develop a structured plan to review implementation of the action plan. This should include a proposal for identifying measurable change and be comprehensible to service users, carers, victims and others with a legitimate interest.
 - Within 12 months conduct an assessment on the implementation of the Trusts action plans in conjunction with the CCG and Trust and feedback the outcome of the assessment to NHS England North.

- 2.19 Section 6 provides a review of the trust's internal investigation into the fall and subsequent fracture, and reports on the progress made in addressing the organisational and operational matters identified.
- 2.20 Section 7 sets out our overall analysis and recommendations.

3 The care and treatment of F and Maureen

About F

- 3.1 At the time of the incident, F was an 87 year old man from the east of County Durham. He had been brought up in a family of nine children. He had been married to his wife for 60 years, and they had had one son who had died aged 55.
- 3.2 F had held various jobs; as a Joiner, Turf Accountant and had been in the RAF reserves. He was also an entrepreneur and had bought his wife a grocery shop and Bingo Halls.
- 3.3 He had always been keen on keeping fit and had ran Judo classes in local schools and clubs. He was described as a perfectionist who liked to get his own way. He also looked after all the finances for the family and the shop.
- 3.4 His nephew described him as a gentleman who would never hurt a woman. At the same time he did not like bigger people trying to intimidate him and was quite capable of knocking them down.
- 3.5 F had first presented with cognitive impairment to Mental Health Services for Older People (MHSOP) in 2006. He was referred again to MHSOP by his GP in 2009, scoring 23/ 30 on a Mini Mental State Examination. He was diagnosed with Alzheimer's disease.
- 3.6 He was first admitted to Picktree ward in in January 2014, under Section 2 of the MHA. This had followed a deterioration in his mental state when he had been living at home with his wife, and had become increasingly confused, agitated and aggressive. He settled reasonably well and was discharged home in February 2014 with a full package of care from the MHSOP community mental health team and a care coordinator.
- 3.7 In November 2014 F's wife had fallen, and sustained a fractured neck of femur. F attended hospital with her, but became disoriented, agitated and aggressive. He assaulted four members of the A&E staff. He was admitted to Ceddesfeld ward under Section 2 MHA following a mental health act assessment. Following this episode both he and his wife were admitted to Jack Dormand Care home, as they could no longer manage to live independently.
- 3.8 In spring of 2015 he had become increasingly agitated and aggressive again. The community psychiatric nurse (CPN) was asked to call in urgently to assess F, as the care home felt they could no longer manage him due to his unpredictable behaviour.

- 3.9 When initially placed in the care home he had responded to Risperidone¹¹ and been more settled, but this had recently changed. The CPN had discussed a medication change with the consultant psychiatrist before visiting the care home. The consultant psychiatrist had agreed that a small dose of carbamazepine¹² might be helpful to reduce the aggressive and unsettled behaviour.
- 3.10 On the visit of the CPN, F appeared unsettled. He told the CPN that he was very unhappy and wanted to die, and that he felt like a prisoner. He was disoriented in time, date and place, and was unable to recognise the care home staff or the CPN even though he had met her on several previous occasions.
- 3.11 It was reported that F had hit a member of staff, hit a drugs trolley and pulled a radiator off the wall. He was reported to be targeting male members of staff.
- 3.12 There was no evidence of aggression during the assessment, but the care home staff reported they were afraid of him. Although a change in medication was offered, the care home staff refused to try it as they felt it would not be effective.
- 3.13 Based on this assessment the CPN requested a MHA assessment.
- 3.14 The MHA assessment was completed by an Approved Mental Health Practitioner (AMHP)¹³ and two Section 12 doctors.¹⁴ Although noted to be more settled than on previous visits, he was noted to be dysphasic¹⁵, and more disoriented.
- 3.15 It was noted that he had dementia with behaviour that challenges, verbal agitation and sometimes physical aggression. Both he and wife had been resident in Jack Dormand care home for the previous six months. F had been staying in the locked EMI (Elderly Mental Ill) residential wing, and his wife in the standard residential care facility. His wife had also been reported as drinking alcohol to excess, which had exacerbated the situation with F as he got frustrated with his wife.
- 3.16 The clinical record notes reports of F's increasing agitation: he had dismantled a radiator, punched a drug trolley, punched a female member of staff, and

¹¹ Risperidone belongs to a group of medicines called antipsychotics. It is licensed for short term use.
<http://patient.info/medicine/risperidone-risperdal>

¹² P Carbamazepine is an antiepileptic drug sometimes used to treat aggression in dementia.
patient.info/medicine/carbamazepine-for-epilepsy-carbagen-tegretol

¹³ AMHPs are mental health professionals who have been approved by a local social services authority to carry out certain duties under the Mental Health Act. They are responsible for coordinating mental health act assessments and admission to hospital if a patient is sectioned.

¹⁴ A section 12 approved doctor is a medically qualified doctor who has been recognised under section 12(2) of the Mental Health Act (1983) amended (2007). They have specific expertise in mental disorder and have additionally received training in the application of the Act.

¹⁵ Dysphasia is a partial or complete impairment of the ability to communicate resulting from brain injury.
<http://medical-dictionary.thefreedictionary.com/dysphasia>

attempted to punch other staff. It has also been noted elsewhere that F has a background in martial arts, and can be intimidated by larger men.

- 3.17 Because of the escalation in his behaviour, and the difficulties experienced by the care home trying to manage his needs it was agreed F needed admission to a mental health ward under Section 2 of the MHA.
- 3.18 F was admitted to Ceddesfeld Ward, Auckland Park Hospital at 10.15pm on 7 April 2015, because there were no beds available on Picktree ward at that time. He was accompanied by the AMHP and a senior care worker from the care home.

Summary of F's care during this admission¹⁶

- 3.19 On admission, F was disoriented in time and place. He was assessed with a very low score (0/10) on the Abbreviated Memory Test Score (AMTS). He received routine blood tests, with no abnormalities detected. However, his admission physical assessment by the doctor identified reduced air entry to the lower left side of his lung, and he was sent for a chest x-ray on 8 April.
- 3.20 An initial falls assessment is reported to have identified him as a low falls risk, despite scoring one tick for agitation / confusion and the medication he was on. The Hip decision support tool graded him as red / amber and he was to receive a physiotherapy assessment on 8 April. This assessment indicated a good range of movement, and that F did not need any further physiotherapy intervention.
- 3.21 By the afternoon of the 8 April he had received his chest x-ray, and had his ECG¹⁷ recorded. He is reported to have been initially unsettled during his stay on Ceddesfeld.
- 3.22 F was transferred to Picktree ward on 10 April when a bed was available. Prior to transfer he had been reviewed by the nurse consultant, who identified that F could be very dizzy, and he was to have daily lying and standing blood pressure monitoring. It was also recorded he had a prolonged QT interval,¹⁸ and would require a repeat ECG. F was noted to be unpredictably aggressive.
- 3.23 On 12 April he became quite angry, wanting to leave and demanding to go home and would not listen to staff explanations. He threatened to "smash the place up" and picked up and threw a table. He was given 'as required' lorazepam¹⁹ 0.5mg and soon settled.

¹⁶ We have provided a more detailed chronology in the appendices.

¹⁷ An electrocardiogram (ECG) is a simple test that can be used to check the heart's rhythm and electrical activity. <http://www.nhs.uk/Conditions/electrocardiogram/Pages/Introduction.aspx>

¹⁸ Long QT syndrome is a heart rhythm disorder that can potentially cause fast, chaotic heartbeats. These rapid heartbeats may trigger a sudden fainting spell or seizure. It can be a side effect of antipsychotic medication, like Risperidone.

¹⁹ Lorazepam has a calming effect. It is prescribed for several different conditions. <http://patient.info/medicine/lorazepam-a-benzodiazepine>

- 3.24 It was notable that F would often refuse to put on his night clothes, which was a feature of this admission. He was generally independent with his self-care, with some prompting.
- 3.25 He was reviewed daily in the 'report out' (the daily multi-disciplinary meeting on the ward), and an initial admission meeting was arranged for the 23 April. The notes often record that he was unsettled at times, "a little wandersome" and disoriented. He was regularly reported to be assessed using the Early Warning Score (EWS)²⁰ with no indications of any concerns arising and a score of 0 or occasionally 1.
- 3.26 On the night of 21 April, he refused his supper, and became very agitated and aggressive. He demanded that everyone leave, and threw a cup of tea over a member of staff. He then hit another member of staff on the hand with the cup. He needed to be restrained by the staff, and was given 0.5mg 'as required' lorazepam.
- 3.27 The admission meeting held on 23 April discussed that it was unlikely he would go back to the Jack Dormand Care Home, and that alternative arrangements would need to be made.
- 3.28 On 25 April Patient Maureen was heard to scream, and staff found her to be extremely agitated, invading F's personal space in the corridor. F was holding up a walking stick, with Maureen shouting at him. Maureen told staff that F had hit her on the arm with the stick, which F denied. Maureen was checked for injury but none was found.
- 3.29 F was involved with another altercation with a different patient on 26 April. He was found standing over a male patient attempting to bite his face. He stated that the other patient had attacked him, but this wasn't corroborated by the staff who had witnessed the altercation. He was placed on Enhanced Visual Observations (EVO).²¹
- 3.30 A formulation meeting was held on 27 April involving the clinical psychologist, F's wife and the full multi-disciplinary team (MDT).²² This identified F's need for respect, feeling in control and having space, and triggers such as people bigger than him, people standing over him, bad language, and his separation from his wife. The notes recorded his risk of aggression if he felt threatened

²⁰ Early Warning Score is a regular (initially daily) physical assessment tool used to alert clinical staff of a deterioration in patient's physical health. Staff record blood pressure, pulse, oxygen saturation levels, temperature and level of consciousness. Each result outside normal limits for the patient are given a score. Scores of 1 – 3 indicate a need for more regular observation recording, and scores of 4 and above or a deterioration of more than two points require medical assessment. Any score of six and above requires immediate medical assessment, application of oxygen therapy, and possibly a 999 call.

²¹ The Trust Engagement and Observations procedure states that 'Enhanced Observation – within eyesight means the patient should be kept within eyesight and accessible at all times during the periods specified for this level of observation and if deemed necessary, any tools or instruments that could be used to harm themselves or others should be removed.'

²² A clinical formulation, is a theoretically-based explanation or conceptualisation of the information obtained from a clinical assessment. It is most commonly used by clinical psychologists and psychiatrists. In this case it is a needs led approach to understand the underlying causes of challenging behaviours, so that plans can be put in place to help manage them.

and suggested ways staff could mitigate these risks and how to respond if intervention was required.

- 3.31 On 28 April, the Trust Safeguarding advisor was notified of the most recent incident on 26 April and it was suggested that the local authority safeguarding team be notified.
- 3.32 On 29 April patient E stopped in front of F, and said something, then slapped F across the cheek. A member of staff intervened, but whilst they had their back to F he retaliated and punched E in the face, requiring further staff intervention and separation of patients.
- 3.33 A safeguarding alert was completed on 30 April. F was reviewed by the consultant psychiatrist, and his unpredictable aggression and violence was noted. It was also recorded in the notes that an application to detain F under Section 3 of the MHA would be made.
- 3.34 F was regraded to 'general observations' after discussion between the MDT in 'report out' on 5 May. At the same time it was recorded that the care home were not keen to take him back due to his unpredictable behaviour, and that a Section 117²³ meeting needed to be arranged to plan his discharge.
- 3.35 Later that day, at tea time, F approached fellow patient D who was sat eating. F picked up D's stick, who reached out to stop F taking it. F struck D on the right arm with the stick. Staff intervened, blocking another attempt to hit D from F. F was escorted away from D. F was placed on EVO again, and the Trust safeguarding advisors were to be contacted. F stated he felt in danger.
- 3.36 F was regraded to 'general observations' on 7 May. He remained more settled over the next week without further incident until the 15 May. Before then he had been reviewed by the consultant psychiatrist, who noted his aggression, but that it was 'only towards men'. Later that day a Section 117 meeting was held with the MDT, his wife and niece in attendance. F's unpredictable violence and aggression was noted, and the need for a more suitable placement which could manage his challenging behaviour was agreed. The social worker was to help his wife find this placement.
- 3.37 During the night of the 15 May, F slept until 1.00am, then woke up. He was very aggressive, refusing to believe why he was in hospital. He raised a stick, and required restraint by the nursing staff. He eventually stopped behaving aggressively, and was allowed to wander around the ward. He was given an 'as required' dose of 0.5mg of lorazepam for agitation.
- 3.38 On the night of 17 May, it is recorded that F got into a verbal altercation with another patient, C, and was again given 'as required' lorazepam.

²³ For people who have been detained under Section 3 of the MHA, it is the duty of the clinical commissioning group and of the local social services authority to provide (without charge) or arrange for the provision of, in co-operation with relevant voluntary agencies, after-care services for any person to whom this section applies until such time as the clinical commissioning group and the local social services authority are satisfied that the person concerned is no longer in need of such services.

- 3.39 On the morning of 19 May in the daily report out meeting it was noted that F was lower in mood but not as argumentative. He was reviewed later that afternoon around 3.00pm, where it was noted that his risk of unprovoked and unpredictable violent behaviour remained.
- 3.40 At 3.30pm F was sat quietly in a chair outside the office. Maureen told him to get out, as it was her chair. Staff immediately intervened and attempted to defuse the situation, encouraging Maureen to walk away. As they were doing so, Maureen swiped at F's face with the corner of her cardigan. F jumped up and pushed Maureen in the back. This caused her to fall to the floor.
- 3.41 F was taken away from the scene for a walk in the garden. He was initially quite angry and distressed, saying "I am the black sheep, and if anyone hits me, I hit them back harder, and no one can hit harder than me". F soon settled, then had a sleep. On waking he made no further reference to the incident.
- 3.42 His family were informed of the incident and he was placed on 1:1 'visual engagement observations'.

About Maureen

- 3.43 Maureen was a 69 year old lady who had first had contact with MHSOP in August 2014 after being referred by her GP for assessment of her memory. She also had a history of Chronic Obstructive Pulmonary Disease (COPD) and asthma.
- 3.44 She was first seen by a CPN on 21 August 2014 in the Blackhall clinic, with a recent history of forgetfulness, confusion, irritability and low mood over the last six months. She had scored 16 on the Six Item Cognitive Impairment Test (6CIT).²⁴ This indicated significant cognitive impairment. She was also tested using the Addenbrookes Cognitive Assessment III, (ACE III) scoring 65/ 100. Her lowest scores were for memory and fluency. A CT²⁵ scan was requested and she was to be followed up in an appointment with a consultant psychiatrist on 4 November 2014 for a diagnostic meeting.
- 3.45 She was initially cared for at home by her husband, with support from Durham County Carers group. However, by 20 October, he admitted to the consultant psychiatrist's secretary that he was having difficulties coping, and that he was having to go for a drive to calm down. He was offered respite care for Maureen on 31 October, but declined.
- 3.46 At the end of November Maureen had a short period of care (four days) in University Hospital North Tees, after being admitted for a chest infection which exacerbated her dementia. She was seen shortly after this by the consultant

²⁴ The 6CIT is a well validated tool that is used to test orientation in time and place, and short term memory. It is an alternative to the MMSE, and is usually used in primary care. Questions are scored 0 for correct answers. Overall scores above 8 / 28 indicate cognitive impairment.

²⁵ A computerised tomography (CT) scan uses X-rays and a computer to create detailed images of the inside of the body. <http://www.nhs.uk/conditions/CT-scan/Pages/Introduction.aspx>

psychiatrist, who gave a likely diagnosis of Alzheimer's Dementia. She was prescribed Pregabalin²⁶ for her anxiety and Donepezil²⁷ to help with symptoms of Alzheimer's, to commence after the antibiotic treatment for her chest infection had been completed.

- 3.47 Initially this had a positive effect, and Maureen was much more settled at home, and her husband was able to care for her.
- 3.48 However by the end of December and into early January 2015 there were further episodes of her husband calling the service saying he could no longer cope, due to a lack of sleep. Other support provided also include attending a day service for respite, and contact with a social worker from the Coal Industry Social Welfare Organisation (CISWO).
- 3.49 Maureen was reported to believe she had two husbands, one who looked after her and one who went to work. She was found to be ironing two sets of clothes for the two husbands. Her husband also reported she had started seeing a girl in the house, but Maureen stated this wasn't a problem as she thought the girl lived with her.
- 3.50 Because the community mental health team felt that her husband could sometimes misconstrue plans agreed with him, further visits from the CPN were to be accompanied by one other member of staff. Maureen's medication was reviewed and her Donepezil was increased to 10mg once a day.
- 3.51 There were further problems with contacting her husband, as his mobile phone blocked numbers it didn't recognise, and he hadn't responded to attempts to contact him from the community team.
- 3.52 Her husband reported in February 2015 that she seemed to be hallucinating more than normal, and there were occasions when she did not recognise her husband. On one occasion she thought he was an intruder and was going to call the police.
- 3.53 Maureen had been attending Minerva House, a dementia day service in East Durham. However, she stated that she no longer wanted to attend, as it was full of old people, and she preferred to be in her own home. Her husband had been on sick leave from work, but was planning to return to work and it was arranged for Maureen's daughter to sit with her for two days a week whilst he was at work. The CISWO had arranged for the enhanced rate of attendance allowance to be paid, and was sorting other benefits for the family as well.
- 3.54 There were periods in February of apparently settled behaviour, then further telephone calls from her husband saying he could no longer cope. He was also often critical of the services, and concerned that the people he wanted to speak to weren't available when he wanted.

²⁶ Pregabalin can be helpful in treating the symptoms of generalised anxiety disorder.
<http://patient.info/medicine/pregabalin-lyrica>

²⁷ Donepezil (known as AChE inhibitors) can be prescribed for people with Alzheimer's disease.
<http://www.nhs.uk/Conditions/Alzheimers-disease/Pages/Treatment.aspx>

- 3.55 Following a joint visit from her CPN and the Team Manager, a plan was agreed with her husband for Maureen to attend the Hawthorns, a day service in Peterlee for people with complex dementia, after discussion with the consultant psychiatrist. The Donepezil was stopped, as sometimes it can increase agitation, and the GP was informed of the plan.
- 3.56 Maureen's husband was increasingly less able to cope. The welfare officer from the CISWO telephoned the community mental health team with her concerns about Maureen's husband, who she stated appeared to be suffering with increased stress. Apparently Maureen was awake all night and responding to hallucinations. Maureen's husband alleged that he had slapped his wife in frustration, and out of exhaustion due to lack of sleep. She had another chest infection which had exacerbated her COPD and she was on antibiotics and steroids. Although there were no marks of injury, and no evidence that this had happened, a safeguarding alert was raised with local adult safeguarding.
- 3.57 Following further carer crises, it became necessary to admit Maureen to a care home in Peterlee for emergency respite care on 26 March. An emergency Deprivation of Liberty Safeguards²⁸ detention was applied for and accepted.
- 3.58 However, over the following few weeks, Maureen's condition deteriorated further whilst in the care home. There were signs that her chest infection had got worse, but that was not seen as a reason to explain her mental deterioration.
- 3.59 On the 17 April, she was reported to have been attempting to hit other residents, walking round communal areas in her underwear, disinhibited and climbing over furniture. She was described as 'manic' and care staff were struggling to cope. She was seen by her consultant psychiatrist, and in order to prevent further decline in her condition, and for the safety of other residents, a recommendation for detention under Section 2 of the Mental Health Act was made.

Summary of Maureen's care during this admission

- 3.60 Maureen was admitted to Picktree Ward, Lanchester Road Hospital, Durham on 17 April 2015 under Section 2 of the MHA. She was brought in accompanied by her daughter and the AMHP (social worker). Though initially settled, she became unsettled after her daughter had left, with some confusion

²⁸ The Mental Capacity Act Deprivation of Liberty Safeguards
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/437661/Final_DoLS_Guidance_2015.pdf

and a little anger. Staff attempted to provide her with her rights under the MHA but she would not engage with them.

- 3.61 She was assessed on admission, and her Glasgow Coma Scale²⁹ (GCS) was 15, and the Early Warning Score (EWS) was 6. The on call doctor was informed, who requested repeat EWS scoring. Maureen received an ECG and she was physically examined by the on call doctor, who was content that she stay on the ward. She was commenced on antibiotics. Maureen had her EWS taken a further three times, scoring 4, and then 3 on the final two occasions, when she was in bed.
- 3.62 The falls assessment indicated a score of 4 ticks on admission (4 or more medication, restless at night, wandering and agitation), and she was placed on the Falls Clinical Pathway (CLIP). As Maureen was reported to have lost weight recently she was commenced on a diet and fluid chart and fluids were 'to be pushed. Her weight was 39.2kg and height at 149.5cm. This gave her a body mass index of 17.8, which is considered underweight.³⁰
- 3.63 There is a record of the FRAX[®] tool³¹ being completed to assess her risk of hip fracture or osteoporosis, which gave her a score of a 12% probability of major osteoporosis and 4.6% probability of a hip fracture over the next ten years.
- 3.64 Initially Maureen's mood would fluctuate, and she could be quite hostile. On one occasion she was found to have taken her trousers down on the ward and was thought to be sexually disinhibited.
- 3.65 She accused a fellow patient of slapping her on the 18 April, but there was no evidence that this happened.
- 3.66 Maureen needed help with dressing as she couldn't coordinate properly, and also prompting with diet. She was seen by the physiotherapist on 20 April, and found to have full range of movement. The physiotherapist took Maureen off the falls CLIP.
- 3.67 At an MDT meeting on 21 April she was noted to be disoriented and confused, with moments of agitation and 'accelerated behaviour' (rushing around).
- 3.68 She was often given 'as required' lorazepam 0.5mg for her agitation. She received this on 18, 19, 20, 23, 24, 25 and 30 April, and 3 May. Most of these doses were given in the evening, apart from midday on 23 and 9.00am on 25 April.

²⁹ The Glasgow Coma Scale provides a practical method for assessment of impairment of conscious level in response to defined stimuli. A patient is assessed against the criteria of the scale, and the resulting points give a patient score between 3 (indicating deep unconsciousness) and 15 (indicating full consciousness).
<http://www.glasgowcomascale.org/>

³⁰ A normal BMI is considered to be between 18.5 and 24.9.

³¹ The FRAX[®] tool has been developed to evaluate fracture risk of patients at the metabolic diseases unit, University of Sheffield. It is based on individual patient models that integrate the risks associated with clinical risk factors as well as bone mineral density (BMD) at the femoral neck.

- 3.69 The general trend of her EWS scores was downwards, and by the end of April her scores were ranging between 2 and 4. However, the fluctuating agitation could cause her problems with her breathing leading to increased respiratory and heart rates and reduced oxygen saturation levels and her EWS score would elevate to 5 and on occasion 7.
- 3.70 By the end of April she was much more settled. She still had episodes of agitation and accelerated behaviour, but they were less frequent. She was engaging well in ward activities, and her husband visited quite often. He noticed an improvement in her condition, and by 27 April was reported to be talking about having his wife home.
- 3.71 At the admission meeting on 30 April with the MDT and her husband, the reasons for her admission were discussed. Her husband admitted to feeling under a lot of stress and said he had told people he had hit his wife because of the stress, but that he hadn't hit her. The outcome of this meeting was to continue with the assessment process.
- 3.72 Maureen had an episode of disorientation leading to confusion and causing her EWS scores to rise to 7 but later reducing to 4 on the 30 April.
- 3.73 She was reported to be independent in dressing and self-care, but was quite disoriented in time and place. She was also anxious on occasions.
- 3.74 On the night of 3 May she became quite agitated, causing her to get out of breath. She was given her 'as required' dose of lorazepam 0.5mg, but also required to have two puffs of her salbutamol³² inhaler, and then zopiclone³³ 3.75mg to help her sleep.
- 3.75 By the MDT meeting on 5 May, Maureen was noted to be much improved, still having some anxious episodes, with periods of acceleration where she would pace quickly around the ward, and at times being argumentative but overall no management problem. Her husband was happy to have her home, with a care package. He was also offered carer's education.
- 3.76 Maureen continued to gradually improve, with occasional episodes of agitation.
- 3.77 She was reviewed by the consultant psychiatrist on 7 May who found her speech was coherent but irrelevant most of the time. Though her improvement was noted, the consultant psychiatrist felt Maureen remained at risk due to her deteriorating mental health which could negatively affected her physical health and safety. The consultant psychiatrist therefore concluded that a MHA assessment was required to regrade Maureen's section from a Section 2 MHA to a Section 3 MHA, as the Section 2 due to expire in one week and Maureen

³² Salbutamol is a bronchodilator medicine because it dilates (widens) the airways.
<http://patient.info/medicine/salbutamol-inhaler>

³³ Zopiclone tablets are sleeping pills (hypnotics) which work by acting on the brain to cause sleepiness.
<https://www.medicines.org.uk/emc/medicine/18157>

would not be able to go home without a comprehensive care package being put in place.

- 3.78 Maureen was then discussed in a pre-discharge meeting / Section 117 MHA meeting with the consultant psychiatrist and MDT. It was discussed that Maureen was calmer and more pleasant. She also presented as disorientated to time and place and was unable to tell who were her daughter and husband. The outcome of the meeting was a plan for the Occupational Therapist (OT) to carry out ward and home based assessments prior to discharge if the assessment were successful. Maureen was granted home leave, and for graded home leave prior to discharge.
- 3.79 Maureen maintained this steady improvement with occasional episodes of agitation. She was frequently noted to be more settled, and interacting pleasantly with the other patients and engaging in ward activities.
- 3.80 Maureen was reassessed under detained regraded to Section 3 MHA on 12 May.
- 3.81 She had a further episode of anxiety on the night of 12 May, when she said she couldn't get her breath and her oxygen saturation³⁴ went down to 93%.³⁵ She insisted on having a cigarette, despite the staff advice not to. She was given her prescribed inhalers, and eventually settled.
- 3.82 On 14 May, a section 117 meeting needed to be arranged to plan for her discharge. She was reviewed by the consultant psychiatrist and her chest infection was noted to be resolved. She was assessed as appropriate in speech and behaviour, and euthymic, but with no insight in to her mental health problems. The home assessment with the occupational therapist (OT) was planned for the 19 May.
- 3.83 On 15 May she was visited by her husband who was looking forward to having her home.
- 3.84 On the night of the 16 May she became quite agitated, coming out of her room in a state of undress and shouting at people. She eventually accepted her night time medication and settled.
- 3.85 On the night of the 18 May, Maureen was reported to be anxious at the start of the night shift, believing she was getting married in the morning. She became breathless with exertion and anxiety. She accepted medication including inhalers, which improved her breathing and she relaxed. She retired to bed,

³⁴ Oxygen saturation is a measure of how much oxygen the blood is carrying as a percentage of the maximum it could carry. <http://www.pulseox.info/pulseox/what2.htm>

³⁵ According to the British Thoracic Society, the recommended target saturation range for acutely ill patients not at risk of hypercapnic respiratory failure is 94–98%. Some normal subjects, especially people aged >70 years, may have oxygen saturation measurements below 94% and do not require oxygen therapy when clinically stable <https://www.brit-thoracic.org.uk/document-library/clinical-information/oxygen/emergency-oxygen-use-in-adult-patients-guideline/appendix-1-summary-of-recommendations/>

but was slow to settle, coming out of her room on occasions, confused and sometimes angry.

- 3.86 On the 19 May Maureen was reported to be bright in mood during the morning, before going home for her OT assessment.
- 3.87 Following the home assessment, the OT noted that it had gone well and Maureen was bright in mood on her return, and enjoyed telling staff about her time at home.
- 3.88 At the MDT meeting that afternoon with the consultant psychiatrist, registrar, staff nurse and CPN, Maureen was noted to be settled though confused, getting breathless when anxious, but accepting 'as required' medication with good effect.
- 3.89 Maureen's husband was keen to care for his wife without a formal care package with the exception of day care. The OT noted there was no evidence of carers stress and acknowledged Maureen's husband was keen to have his wife home and was now accepting of community support.
- 3.90 Maureen's husband was noted to be committed to the caring role for his wife, and he had demonstrated insight and good care strategies to meet his wife's needs. Following the home assessment the OT recommended discharge home without a graded leave programme.
- 3.91 After her return from the home visit on 19 May 2015, Maureen was walking from her bedroom to the ward dining area with a member of staff accompanying her. At approximately 3.30pm Maureen approach a male patient (F) telling him to "get out of my seat". The staff member with her attempted to divert Maureen away from F. As Maureen walked away from F she gestured / lashed out at F with her fleece. She had her hand wrapped in her fleece. Maureen continued to then walk away with the staff member. At that point F jumped from his seat and pushed Maureen in her back causing her to fall to the floor landing on her left side.
- 3.92 On landing on the floor Maureen was upset and complaining of pain to her left leg. This was rotated to the left with some shortening of the limb. She was seen by the registrar who was on the ward at the time. An X-ray request was completed and ambulance called. Maureen was made comfortable on the floor with pillows behind her back. She was given as required 1g paracetamol for pain. The Glasgow Coma scale was completed, and she scored 15, indicating mild neurological injury. As Maureen was wearing a large jacket and staff were reluctant to remove the jacket due to the pain they would cause Maureen in trying to move her, her blood pressure was not taken. EWS was therefore partially completed. Temperature taken 37.3° C, pulse 117/minute, Oxygen Saturation at 95% and respiration 20/minute.
- 3.93 There are records of telephone discussions between ward staff and the ambulance service regarding transfer timings and advice to ward staff from the ambulance service during the wait for the ambulance. Eventually the ambulance arrived and Maureen was taken to the A&E at University Hospital

North Durham (UHND) at 5.30pm. She was escorted by a nursing assistant and a copy of her prescription sheet, personal information sheet and X-ray request was sent with her.

- 3.94 Maureen's husband was informed of the incident and kept up to date with information. He is reported to have been understanding of the situation.
- 3.95 Maureen was transferred to Ward 12 UHND that evening. Picktree ward staff remained with Maureen through the night in case she became unsettled or agitated. A fractured neck of femur was confirmed and Maureen underwent surgery for a hip repair in the morning.
- 3.96 Picktree ward staff updated her husband on her progress, though there remained difficulties getting through to him from hospital phones routed via switchboards, and staff had to use a mobile phone.
- 3.97 Maureen's condition worsened after her surgery. She went into urinary retention, and staff (including a urologist) were unable to catheterise her. She was given a suprapubic catheter on 23 May. Her oxygen levels were low post operatively, and she was diagnosed with a chest infection and given intravenous antibiotics. However she did not respond to the antibiotics, and went into sepsis.
- 3.98 Maureen died at 9.30am on 25 May 2015.

4 Arising issues, comment and analysis – F's care

Assessments

- 4.1 F received a comprehensive suite of assessments from his admission to Ceddesfeld ward and during his stay on Picktree ward until the date of the incident.
- 4.2 There are records of the following assessments within the Supplementary Case Notes folder:
 - ECG's taken on 8, 9 and 13 April 2015.
 - Behaviour/ Mood charts completed every day from 12 April up to 10 May 2015.
 - Food chart measuring diet and fluid intake, completed every day between from 10 April up to 10 May 2015.
 - Sleep charts completed every night from 10 April to 29 April.
 - Abbey Pain Score completed on 7 April 2015, graded at 0 (no pain).
 - Waterlow (Pressure Sore Risk Assessment Tool) assessment completed on 7 April, graded at 6, 19 April graded at 9 and 17 April graded at 6 (all scores below threshold for intervention).

- MUST (Malnutrition Universal Screening Tool) completed on 7 and 14 April.
- Falls decision tool completed on 16 April (scored '3 ticks' in Amber category, indicating placement on falls pathway).
- Communication Screening Tool completed on 8 April.
- FACE (OP)³⁶ assessments completed on 10, 26, 30 April and 6 and 19 May.
- POOL Activity Level (an Occupational Therapy assessment tool to indicate a person's ability to complete certain tasks) on 7 April, graded at 9 which indicates ability to undertake planned tasks.
- FRAX[®] tool (Risk of fracture) tool undated/ unsigned, graded at 8.7% probability of major osteoporosis and 5.8% probability of a hip fracture in the next ten years.
- Bristol Activities of Daily Living on 7 April (a 20-item questionnaire designed to measure the ability of someone with dementia to carry out daily activities such as dressing, preparing food and using transport). F scored 0 indicating full ability, including 0 for orientation in time (indicating fully oriented in time and date), 0 for orientation in space (indicating fully oriented in place) and 0 for transport (indicating able to drive, cycle or use public transport independently).
- Mental Health Act assessment for admission on 7 April.
- Physical Observation and Early Warning Score assessments completed daily from 7 April to 15 May completely, with several days (13, 18 and 20 April) when it was completed four times a day.
- Blood tests:
 - Thyroid Stimulating Hormone (TSH) and B12 and Folates levels on 8 April
 - Full Blood Count (FBC) on 8 April, 29 April and 12 May

4.3 In addition to this, within the narrative daily record printed from PARIS³⁷, we noted the following:

- Abbreviated Mental Test Score (AMTS) scoring 0/ 10. Completed by doctor on admission assessment
- Falls decision tool completed on admission, scoring one tick for agitation/ confusion and medication he was prescribed. Assessing nurse judged that F did not need to be placed on Falls CLIP due fully independent mobility and no history of falls from the care home.
- Hip decision support tool completed, amber and red scored on 8 April.

³⁶ Functional Assessment in Care Environments (FACE) is an evidence based assessment tool for assessing risk in mental health and learning disability services. The OP indicates suitability for older people.

³⁷ PARIS is the electronic clinical records system used in TEWV

- Glasgow Coma Scale on admission (7 April) scoring 14 (out of 15).
- Preliminary Physiotherapy Assessment (PPA) using Problem Oriented Assessment of Mobility (POAM)³⁸ on 8 April, identifying no need for further physiotherapy assessments.
- Falls CLIP assessment commenced on 16 April and completed on 30 April. No falls formulation noted.
- A comprehensive psychological formulation, using the 'Columbo'³⁹ model, undertaken on 27 April with full MDT involvement. This identified that F needed to be taken seriously, and treated with respect. He liked to talk to women, and could be charming and gentlemanly. He liked to feel useful, but could find larger men intimidating. The formulation identified triggers for behaviour (people bigger than him, separation from his wife, bad language, someone standing over him). Recommendations were to treat F with respect, be aware he may find larger men intimidating, that F usually responded better to women, take him seriously, and provide an open environment with space.
- Large Allen Cognitive Level Screen (LACLS) score 3.6, was completed on 20 April by Occupational Therapist. Noted to have limited concentration span, be easily confused. Summary identified that although falls were self-reported, there was no evidence of these. F was disoriented to time and place, but needing minimal supervision with self-care activities. No interventions implemented as a result of assessment.
- Blood sugar taken on the evening of 2 May after F complained of feeling dizzy, with result of 5.4mmols/ litre.⁴⁰
- POOL Activity Level Pool Activity Level (PAL)⁴¹ completed on 16 April. F scored at the planned level. The assessment noted that F may be able to look in obvious places for objects, that he couldn't understand complex sentences, and that the care giver may need to solve problems that arise for him.
- Other on-going medical and psychological assessments documented as 'review', as part of his admission and care process.

³⁸ POAM should mean Performance Oriented Assessment of Mobility. It is more properly called Performance Oriented Mobility Assessment after Tinetti M E (1986) '*Performance Oriented Assessment of Mobility Problems: in Elderly Patients*', Journal of American Geriatrics Society, 34, 2. Tinetti aimed to develop a measure to screen older adults for balance and gait impairments that was feasible for use (i.e., required no equipment and no training to master), was reliable and sensitive to significant changes, and reflected position changes and gait manoeuvres used during daily activities.

³⁹ James, I. and Stephenson, M., 2007. '*Behaviour that challenges us: the Newcastle support model*'. Journal of Dementia Care, 15(5), p.19.

⁴⁰ The British Diabetic Association lists blood sugar levels of under 7.8 mmols/litre at 90 minutes after a meal as non-diabetic. F was within normal limits.

⁴¹ The Pool Activity Level (PAL) Instrument is widely used as the framework for providing activity-based care for people with cognitive impairments, including dementia. The Instrument is recommended for daily living skills training and activity planning in the National Institute for Clinical Excellence Clinical Guidelines for Dementia.

4.4 Despite F receiving a comprehensive suite of multi-disciplinary assessments we noted that not all assessments were dated or signed (for example the FRAX[®] tool assessment), and several of the assessments filed in the Supplementary Case Note Folder that should have had a completed assessment sheet did not have one. These included:

- Glasgow Coma Scale on admission;
- Falls Decision tool on admission;
- Hip Decision tool on admission; and
- the second Pool Activity Level assessment on 16 April.

Care Planning

4.5 Following his admission on 7 April and then on 10 April F had interventions plans for:

- In patient admission and assessment;
- MHA Section; inform of rights;
- Mental Capacity Act: Personal Care;
- General observations; and
- Pool Activity Level Assessment at Planned level.

4.6 Despite the admission assessment noting reduced air entry to his lung such that he required a chest X-ray, there are no interventions noted as a result of this. We do not know the outcome of the chest X-ray, since a written report is not routinely provided, and staff have to manually retrieve the report from the shared information system. No further comment is made in the paper notes regarding this.

4.7 These plans were augmented by the addition of 'management of aggression and prevention of physical harm to others' and a need for 'access and egress around the ward environment' on 21 April.

4.8 On 22 April the intervention plan was further updated with F being identified as 'maybe at risk of falls due to major osteoporosis and the side effects of medication'.

4.9 The outcome of the formulation meeting on 27 April led to the identification of strategies to minimise F feeling upset and disrespected. We discuss these in more detail below.

4.10 Following the incident with patient E, F was placed on EVO. The intervention plan was updated on 30 April. Alongside this, F had been detained under Section 3 MHA and there was a new need to explain his rights to him.

- 4.11 The intervention plan was again updated on 5 May, when F was taken off the EVO, and then these were reinstated on 6 May. There is no updated intervention plan for his return to general observations on 7 May.
- 4.12 Following the incident with Maureen on 19 May he was placed back on EVO and the intervention plan updated.

Comment

- 4.13 There were inconsistencies in the various assessments made of F's risk of falling. The Falls Decision tool was completed on admission. He scored 'one tick for agitation/ confusion and the medication he is currently prescribed'. The assessing nurse did not think F required to be on the falls pathway. However, he was on seven prescribed medications, and the admitting doctor noted a history of 'syncopal attacks'. The 'Hip decision tool' [sic] was completed the following morning, and the PARIS noted record 'amber and red scored' and it was agreed to arrange for a preliminary physiotherapy assessment. This was completed that afternoon (8 April) and the assessment commented that it was not necessary to place F on the falls pathway.
- 4.14 On 10 April F was reviewed by the Nurse Consultant, and documented that F was 'low falls risk so falls CLIP not required however does have dizziness so need regular review'.
- 4.15 In fact, on admission his history of 'syncopal attacks' and dizziness was known. According to his PARIS notes, he was placed on daily sitting and standing blood pressure recording on 10 April after complaining of dizziness, which was very apparent when standing from sitting. It is not clear therefore why he was not seen as a falls risk.
- 4.16 In addition, F had a known recent history of prolonged QT interval since his Risperidone had been increased in March. On 8 April the QT interval was recorded as 499 milliseconds (ms).⁴² His consultant psychiatrist was aware and monitoring this. His ECG was repeated on 9 April with a result of 422ms, and again on 13 April, with a result of 474ms. The medical team were aware of these results. One of the consequences of prolonged QT interval is known to be fainting or syncopal attacks.
- 4.17 After admission to Picktree ward, F was reassessed by the physiotherapist, and again on 13 April. His independent mobility was noted and he was not thought to require further physiotherapy input. This assessment noted that F had no reports of pain yet F had been receiving Paracetamol 1g four times a day since 11 April.
- 4.18 On 16 April the 'Falls decision tool' was completed again. He scored 'three ticks'; one for agitation, one for four or more medications and one for being

⁴² In normal persons, the mean QTc length is roughly 400 ms. The upper limit of normal is 460 ms for women, and 450 ms for men. QTc intervals longer than 500 ms are considered to be a major risk factor for the development of Torsade de Pointes. Reference: Wenzel-Seifert, K; Wittmann, M; Haen, E "QTc Prolongation by Psychotropic Drugs and the Risk of Torsade de Pointes" *Deutsches Arzteblatt International* 2011; 108(41): 687-93; DOI: 10.3238/arztebl.2011.0687 accessed January 2017.
Torsades de pointes is a specific type of abnormal heart rhythm that can lead to sudden cardiac death.

restless at night. He was placed on the Falls CLIP. The recent history of dizziness was not noted. If it had been, this would have been graded as a 'red risk' placing F on the falls pathway immediately.

- 4.19 The Falls CLIP assessment (16 April) notes F was mobilising independently with no history of falls. It also notes that an ECG had been completed, but does not comment on his prolonged QT interval. The pharmacological intervention section notes that five of the medications F was prescribed (memantine⁴³, risperidone, tamsulosin⁴⁴, promethazine and glyceryl-trinitrate⁴⁵) could all increase a falls risk, and that common side effects included hypertension, hypotension, drowsiness, dizziness and syncope.
- 4.20 Again the assessment documents no complaints or history of pain, despite being on paracetamol 1g four times a day. We have been told that the service often gives paracetamol speculatively for people with dementia who have difficulties with verbal language and communicating pain and a recent history of agitation. This is in line with the Alzheimer's Society guidelines.
- 4.21 The assessment also records 'no concerns noted' for the section on Dizziness, Postural Hypotension. By that date only his standing blood pressure was being recorded, but he had been on daily sitting and standing blood pressure since 10 April.
- 4.22 No changes to F's intervention plan were noted as a result of either his dizziness, prolonged QT interval or placement on Falls CLIP.
- 4.23 An Occupational Therapy falls assessment was requested, and completed on 20 April. Again this noted that F was mobilising independently, all transfers were independent and safe, and that no interventions were planned as a result of the assessment.
- 4.24 The Falls CLIP was reviewed in PARIS notes on 22 April, and notes that the only outstanding element was the pharmacy review. It is not clear who completed the entry on 16 April regarding side effects of medication.
- 4.25 On 22 April, F had a new intervention plan which noted he may be at risk of falls due to major osteoporosis and the side effects of medication. This intervention continued to be noted without comment up to the 19 May. This intervention seems a little confused. Firstly, F actually had a low probability of major osteoporosis (8.7% probability of major osteoporosis over the next ten years), and secondly osteoporosis doesn't increase the risk of falls, but increase the probability of fractures arising from a fall. In addition, this intervention is not linked to his prolonged QT interval and risk of fainting.

⁴³ Memantine hydrochloride is used for the treatment of patients with moderate to severe Alzheimer's disease. <https://www.medicines.org.uk/emc/medicine/28823>

⁴⁴ Tamsulosin is used to treat benign prostate enlargement. <http://patient.info/medicine/tamsulosin-for-prostate-gland-enlargement>

⁴⁵ Glyceryl Trinitrate belongs to a group of medicines called nitrate vasodilators. These medicines work by relaxing the blood vessels of the heart. This reduces the strain on the heart by making it easier to pump blood. <https://www.medicines.org.uk/emc/medicine/18092>

- 4.26 We are concerned that in this case the assessment of the risk of falls does not seem to have been consistently and comprehensively applied to all the known risk factors, and aspects (such as ten year probability of major osteoporosis) appear to have been poorly understood. As the assessment of falls, and use of the Falls CLIP is of concern in the care of Maureen, we have made a recommendation concerning this in that section.
- 4.27 However, we have been concerned to note that much of the care planned in the intervention plan is not linked to findings from assessments (for example, reduced air entry leading to a chest X-ray but no known outcome, or the dizziness/ prolonged QT interval and the Falls assessment).

Recommendation 1:

The Trust should assure itself that the findings and observations of patients when admitted to MHSOP wards leads to accurate care planning and appropriate interventions.

Risk assessments and management of aggression

- 4.28 F was admitted under Section 2 MHA because of his unpredictable aggressive and threatening behaviour, with a history of violent assaults and targeting staff. We have some concerns that assessments and care planning did not always translate into practical care intended to minimise incidents of violence.
- 4.29 We were unable to find whether an initial admission FACE (OP) had been completed on admission to Ceddesfeld ward on 7 April 2015. On admission he was placed on general observations.
- 4.30 We noted the 'Intervention Plan' (the plan of care for each patient) dated 8 April after admission to Ceddesfeld ward. There was no specific plan for the management of his aggression, despite this being the reason for admission.
- 4.31 This recorded needs and interventions required for:
- In patient care: admission for assessment;
 - MHA Section 2: informing patients of their rights;
 - Mental capacity; personal care;
 - General observations to maintain safety; and
 - Activities at planned level following POOL Activity Level assessment.
- 4.32 The FACE (OP) completed on 10 April identified a range of risks including current and historical risks of:
- harming others;
 - of impulsivity and lack of control;
 - threats and intimidation

- damage to property
 - falling (due to dizziness)
- 4.33 Within the FACE (OP), one of the final questions asks ‘have actions been taken in the past to reduce risk?’ The assessment answer is ‘Yes’. Beneath this the assessment asks ‘if the answer is yes, please give details’. No details of previous actions taken are recorded.
- 4.34 The Intervention Plan for 10 April notes care plans for:
- In patient care: admission for assessment;
 - MHA Section 2: informing patients of their rights;
 - Mental capacity; personal care;
 - General observations to maintain safety; and
 - Activities at planned level following POOL Activity Level assessment.
- 4.35 We could not see any intervention plan for managing the risk of aggression on admission, either on Ceddesfeld or Picktree ward, although the Mental Capacity: Personal Care plan did identify that F could become resistive or aggressive during interventions. In fact it was 21 April before the intervention plan was revised, with a new plan aimed specifically at managing F’s violence and aggression.
- 4.36 In this revised ‘Intervention Plan’ of 21 April, the interventions identified under the heading of ‘Management of aggression and prevention of physical harm to others’ included: development of the therapeutic relationship; awareness of F’s whereabouts and precipitating factors (such as thwarted attempts to leave the ward); giving prescribed medication; engagement in activities and diversion; if aggression occurs to remain calm and remove the perceived threat from the area; and document incidents using Datix⁴⁶.
- 4.37 On 27 April the ‘Intervention Plan’ is revised again, following the clinical psychologist led formulation meeting. The formulation meeting identified that there were risks of aggression to others from F if he felt threatened or disrespected, and that he may respond aggressively to someone he perceives as interfering with him.
- 4.38 This was translated in the intervention plan into a need for F to feel respected, safe and in control, with interventions of:
- Treat F with respect;
 - Be aware he may find larger men intimidating;
 - Take him seriously;
 - Understand he responds better to women; and

⁴⁶ Datix is an online incident reporting form used in the NHS. <http://www.Datix.co.uk/products-services/modules/uk-and-europe/incident-reporting/>

- Ask him to help in order to get him to engage.
- 4.39 These are very important strategies to minimise and aid staff understanding of the triggers for F's aggression. In addition to this, the intervention plan also notes F's EVO status, and the plan for managing his aggression and preventing harm to others.
- 4.40 On the 29 April, F was approached by Patient E who stopped in front of him and said something, and then slapped F across the cheek. A member of staff intervened, but whilst they had their back to F he retaliated and punched E in the face, requiring further staff intervention and separation of patients. A Datix form was completed.
- 4.41 The intervention plan initiated on 27 April for management of aggression and prevention of physical harm to others is reinforced on 30 April. The intervention is appropriate for preventing F from becoming aggressive. However, it does not consider on how to manage the situation if F is attacked, and how he might retaliate.
- 4.42 F was placed on EVO on 30 April. When reviewed by his consultant psychiatrist on 30 April he was noted to be 'unpredictably violent'. He was also detained under Section 3 MHA on 30 April.
- 4.43 F was taken off EVO on 5 May. There had been no further incidents since the 29 April.
- 4.44 On 6 May at 5.23pm he was put on EVO for less than 24 hours when he approached the table where D was sat eating.⁴⁷ F picked up D's walking stick, and D reached out to retrieve his stick. F snatched it away, then hit D with walking stick. F aimed another blow at D, but staff intervened and removed the stick.
- 4.45 He was regraded to general observations on 7 May at 9.26 am in the 'report out' MDT meeting.
- 4.46 He had one further episode on 16 May when he awoke at 1.00am, and approached the nurse's station brandishing a stick. He was argumentative, refusing to accept staff explanations as to why he was in hospital and telling them to leave his house. He raised his stick, which was taken away from him, and a four arm hold was used to prevent him hitting other staff. During this episode he attempted to head butt staff and sweep their legs from under them. He eventually agreed to stop, and wandered about the ward for 30 minutes before retiring to bed. He later awoke at 5.00am and was pleasant to staff who approached, accepting a hot drink and then going back to bed.
- 4.47 The next recorded incident occurred when Maureen approached him on 19 May, accusing him of sitting in her chair, and which is the signal incident in this investigation.

⁴⁷ The Trust has told us that EVO is used flexibly, and it is not uncommon for some people to have been placed on and off EVO with a few hours, depending on the patients' needs.

Comment

- 4.48 The risk of F being unpredictably violent and aggressive was identified in the FACE (OP) assessment of 10 April. This was also the reason for his admission and detention under Section 2 MHA. Yet there is no intervention plan for this until 22 April.
- 4.49 This identified that all incidents of violence and aggression be recorded in Datix. On two occasions (12 April and 6 May) there appear to be incidents recorded in PARIS which we have not been able to find evidence of being recorded in Datix.
- 4.50 We know that in very many cases, staff working in hospital settings under report incidents of violence and aggression.⁴⁸ It would be understandable if this was even more the case on MHSOP wards. Anecdotally we know that many staff feel that the behaviour is part of the dementing illness and that the patients 'can't help it'.
- 4.51 Much of the narrative content and reviews and summaries of F's behaviour in the PARIS notes fail to correctly identify all episodes of behaviour, and we think it minimises the actual risk of violence and aggression towards women. The FACE (OP) of 19 May, following the incident with Maureen notes the following:
- 19/05/2015 Pushed female patient
 - 06/05/2015 episode of aggression towards fellow male patient
 - 26/04/15 There have been two incidents of aggression today
- 4.52 On 16 April he was reviewed by his consultant psychiatrist, who noted 'there hasn't been a significant episode of challenging behaviour so far, but he was rather verbally threatening on occasion'. In fact on 12 April, F had become aggressive when he couldn't understand the reasons for his detention in hospital. He had thrown a table and had to be restrained. This incident was noted in PARIS, but not reported on Datix.

⁴⁸ Staff exposed to challenging behaviour on a routine basis can over time become 'conditioned' to the behaviour. This is particularly true for the low level behaviours which are historically underreported. This may be because staff are unable to acknowledge, recognize or describe these types of behaviour or perceive them as being a normal part of their duties, leading to the widely used expression: 'It's part of the job'. The 2012 NHS staff survey highlighted that just under two-thirds of incidents of physical violence and 44% of bullying, harassment and abuse cases were reported.

Some of the main reasons for staff underreporting include: • Stoical acceptance and tolerance of staff in the face of adversity • Staff empathising with the ill person and not blaming them • Staff concern that it may reflect poorly on their ability to manage an incident • Reporting being too complicated, time consuming or not suitable for lower level behaviours • Staff perception that no action will be taken to give them adequate support • Lack of management feedback on actions taken to tackle or reduce incidents.

Source: NHS Protect (April 2013) "Meeting needs and reducing distress Guidance on the prevention and management of clinically related challenging behaviour in NHS settings"
http://www.nhs.uk/Document/SecurityManagement/Meeting_needs_and_reducing_distress.pdf

4.53 On 30 April he was again reviewed by the consultant psychiatrist who noted that “since his admission (F) remains unpredictable, significantly aggressive and challenging; he punched another patient and on top of another one”. This seems to under report the frequency and significance of the aggressive episodes. We know that between 12 April and 29 April there were six violent episodes reported:

1. 12 April Wanting to leave, could not understand detention. Became aggressive, threats, threw table, breakaway used
2. 21 April 9.45pm Became agitated and demanded people leave his property, disoriented. Threw cup of tea, hit staff with cup.
3. 25 April 3.18 pm Incident with Maureen. Maureen’s scream heard, found F & Maureen in corridor, F holding up a walking stick, Maureen shouting at him. Maureen said F had hit her on the arm, F denied, no signs of injury on assessment.
4. 26 April Time of first incident unknown. First incident, an altercation with male patient, cause unknown. Both reported other had punched out. No witnesses and no injuries.

6.45pm Second incident with male patient, F attempting to bite his face, stood over him. F reported that other patient had been attacking him, though appeared not to be the case.
5. 29 April 6.40pm Incident with male patient E, when E stopped in front of F, said something inaudible, then slapped F. When staff intervened, had back to F, he retaliated and punched E in the face, several staff intervened and escorted both patients away.

4.54 F was reviewed again by his consultant psychiatrist on 14 May. He was noted to have been on EVO due to incidents of physical aggression, but his aggression was reported to only be towards men, though he remained unpredictable. By this time he had had at least one incident of aggression involving a female patient, Maureen, on 25 April. However, it is not known if there were any incidents of aggression towards female staff.

4.55 We are left concerned that not all incidents of violence and aggression by F were correctly reported. Because of this, whilst there was a recognition of his unpredictable violence and corresponding intervention plans, it appears the true picture of the frequency of the incidents and any risks may have been underestimated.

4.56 There were five incidents in April (12, 21, 25 and 26 x two) before he was placed on EVO on 26 April. He was on EVO for a further nine days, during which he retaliated to an unprovoked attack (on 29 April, when E slapped

him). He was taken off EVO on 5 May, and then placed back on EVO on 6 May after his altercation with patient D and the walking stick.

- 4.57 He was then taken off EVO until the incident with Maureen on 19 May.
- 4.58 In hindsight, following the incident with Maureen on 19 May, we now know that when F had been the recipient of an unprovoked attack, it was as important to prevent any retaliation from F as it was to remove the aggressor from his environment. This was noted in the formulation meeting where it was identified that there were risks of aggression to others from F if he felt threatened or disrespected, and that he may respond aggressively to someone he perceives as interfering with him.
- 4.59 Even with Enhanced Visual Observations, it is unlikely that one member of staff would have been able to prevent any aggressive outbursts from F if they were in retaliation to a perceived aggressive act. The policy states that the patient must be accessible when on EVO. But even if F was accessible, it is likely that it would have taken two staff, one to remove the aggressor, and one to prevent F retaliating. An alternative approach would have been to ensure that Maureen also remained on EVO since she too was predictably unpredictable.
- 4.60 The Engagement and Observation policy is clear:⁴⁹

“3.1.3 Individual Intervention Plans

- Will be based on the clinical assessment of risk for each individual and will clearly state actions staff will take to manage those risks, at what times/ time periods those actions are to be taken and how actions will alter with a change in circumstances and risk.”
- 4.61 In this instance, whilst there was a general intervention plan to prevent aggressive and violent outbursts, a more specific plan based on experience and the outcome of the formulation meeting would have helped staff deal with F’s retaliatory aggression.

Recommendation 2.

The Trust should review management of aggression guidance and the clinical link pathway for Behaviours that Challenge in Mental Health Services for Older People wards to ensure that explicit guidance in how to manage an incident is an outcome of the assessment process and is included in intervention plans.

Compliance with local policies, national guidance and relevant statutory obligations.

Observation policy

- 4.62 In total, F was on EVO for ten days (one initial period of nine days from 26 April to 5 May, then a further day from 6 May to 7 May). We found that recording of observations and compliance with the Trust policy was suboptimal.

⁴⁹ TEWV “Engagement and Observation Procedure: CLIN-0017-001-v1”. Approved March 2014.

4.63 Despite being on EVO, and both the intervention plan and policy requiring recording of the observations, many of the days observations when F was on EVO go unrecorded.

4.64 The policy states:

“The staff who are allocated to deliver enhanced observation will record in the contemporaneous clinical record their involvement, time of their involvement, any evaluation based on the time spent with the patient and whom they handed responsibility over to. Those staff will ensure any pertinent information is handed over verbally when ending a period of enhanced observation.”

4.65 We were unable to find records in the PARIS notes of such observations for when F was on EVO, other than statements such as ‘remains on EVO’. Because it is not recorded, we are unable to comment on the grade and skill of staff undertaking the observations.

4.66 The policy also states:

“Engagement and observation practice will be reviewed at a minimum once every shift handover. Patients on enhanced observations should have their level reviewed and recorded on an ongoing basis but as a minimum every 72-hours.”

4.67 We were unable to find any record that the EVO was reviewed at shift handover.

Recommendation 3:

The Trust should ensure that MHSOP wards fully comply with the policy on recording observations.

4.68 The Trust Engagement and Observation Procedure CLIN-0017-001-v1 references the NICE Clinical Guideline 25 “Violence: the short-term management of disturbed/violent behaviour in psychiatric inpatient settings and emergency departments” from 2005. This was updated in May 2015 and is now NICE Clinical Guideline 10 “Violence and aggression: short-term management in mental health, health and community settings”.⁵⁰

Recommendation 4:

The Trust should ensure that all relevant policies and procedures are updated whenever new guidance from NICE is issued.

Incident reporting and safeguarding

4.69 F was involved in six violent and aggressive incidents between 21 April and 19 May. Of those, a Datix incident report was completed on four occasions according to the PARIS records. The incidents without a record of a Datix report appearing in the PARIS notes were the first incident occurring on 16 April and the incident on 6 May.

⁵⁰ NICE guideline [NG10] Published date: May 2015 <https://www.nice.org.uk/guidance/ng10>

- 4.70 There is only one documented safeguarding alert to the local authority, raised on 30 April following the incident on 29 April where F retaliated to the slap from E. The Trust Safeguarding link was informed of this incident and requested the local authority be informed. The PARIS notes record that Safeguarding were to be informed of the incident on 6 May, and were informed of the incident on 19 May but we were unable to find evidence that this happened.

Comment

- 4.71 We have earlier discussed the potential for a higher threshold of reporting and a raised tolerance of aggression amongst MHSOP staff. Nonetheless, more accurate reporting of incidents and the correct reporting of safeguarding incidents is a significant part of both developing appropriate interventions for individuals and enabling the Trust to understand patterns of harms and incidents and develop strategies and actions to minimise recurrence.

Recommendation 5:

The Trust should develop a programme of increased awareness of the need to accurately report incidents with the MHSOP wards, and assure itself that incidents are being accurately reported.

Person centred clinical link pathway for behaviours that challenge in mental health services for older people⁵¹

- 4.72 The Trust has developed a 'clinical link pathway' for people with behaviours that challenge in MHSOP wards. The pathway itself states that 'a Person Centred Pathway of Care details the locally agreed evidenced based clinical standards for a defined care group'. This pathway contains clear standards for assessments and interventions required for people with behaviours that challenge in the MHSOP service.
- 4.73 The pathway was originally developed for use in Care Homes, and it was acknowledged that adaptations would be needed for use on in-patient wards.
- 4.74 However, despite this pathway having been developed and approved in 2013 it appears that it was not in use on Picktree ward in 2015. Whilst the PARIS notes contain clear evidence of when F was considered suitable (or not) for the Falls CLIP, the same consideration was not given for F with regard to the Behaviours that Challenge CLIP, as this had not been implemented at that time.
- 4.75 However, from our reading of the PARIS records the prescribing practice was largely in line with the guidance recommended in the CLIP. Under 'Pharmacological Treatment Options for the Behavioural and Psychological Symptoms of Dementia' the CLIP suggests that atypical antipsychotics (such as Risperidone) have a role in the treatment of aggression as part of the behavioural and psychological symptoms of dementia:

⁵¹ TEWV "Person Centred Clinical Link Pathway for Behaviours that Challenge in Mental Health Services for Older People (CLIP)". Approved 2013

“Antipsychotics – atypical

Risperidone - short term treatment (up to 6 weeks) of persistent aggression in patients with moderate to severe Alzheimer’s Dementia unresponsive to non-pharmacological interventions and where there is risk to self or others.”

- 4.76 Despite not being on the pathway, this guidance appears to have been followed with regard to F, and his prescription of Risperidone, carbamazepine and memantine.
- 4.77 There are however other incidences where practice fell short of the required standards of the pathway. Had the CLIP been used, the formulation meeting should have been undertaken within seven days of admission, yet the formulation meeting did not take place until 27 April, 20 days after admission. Interestingly, because the formulation meeting did not happen until the 27 April, there were three incidents of aggression from F that the formulation meeting was able to include in its assessment, which would not have happened if the meeting had taken place within seven days of admission as recommended.

Recommendation 6:

The Trust should assure itself that MHSOP wards are now following its own best practice guidance with regards to Behaviours that Challenge in dementia.

5 Arising issues, comment and analysis – Maureen’s care

Assessments

- 5.1 Maureen received a comprehensive suite of assessments following her admission to Picktree ward until the date of the incident.
- 5.2 There are records of the following assessments within the Supplementary Case Notes folder:
- Behaviour / Mood Chart completed every day from admission up to 19 May 2015.
 - Physiological Observation and Early Warning Score Chart (EWS) completed at least daily, from admission upto 19 May. On occasions, completed three, four of five times a day if initial reading elevated. Scores ranging from 6 on admission, 7 on 30 April and mostly around 2 – 4.
 - Falls Decision tool completed on admission (17 April) score = 4.
 - ECG taken on 2 and 17 April.
 - AMHP assessment for Section 2 completed on 17 April and assessment for Section 3 completed on 12 May.
 - Medical recommendations for detention under Section 2 and Section 3 MHA.
 - Blood tests taken on 22 April:

- Urea & Electrolytes
- Liver function
- Bone profile
- Fasting glucose
- Reactive protein/ lipid profile
- Thyroid Stimulating Hormone, Ferritin, B12 and Folate levels (repeated on 15 May)
- estimated glomerular filtration rate (kidney function)
- Mid-Stream Urine (MSU) specimen for microscopy and culture taken on 18 April, results of 18 April recorded on 24 April showed no significant growth of infection, and no action required.
- Fluid balance charts completed on 18 and 19 April and 18 and 19 May.
- Sleep chart completed every night from 17 April to 18 May.
- Food record chart, recording food and fluid intake completed daily between 17 April and 28 April and again from 1 May to 5 May.
- Waterlow pressure ulcer risk assessment, completed on 19 April (score = 5) 3 May (score = 6) and 17 May (score = 6).
- Malnutrition Universal Screening Tool (MUST) tool completed on 17, 19 and 26 April and 3, 10 and 17 May. On each occasion scoring 2.
- NHS Continuing Healthcare Needs Checklist on 6 May 2015.
- There are records of referral to:
 - Faxed referral sent on 19 April to MHSOP Nutrition & Dysphagia team for assessment by dietician

5.3 In addition to this, within the narrative daily record printed from PARIS, we noted the following:

- Admission physical assessment by registrar.
- Admission EWS score of 6, and reviewed by doctor on ward, EWS repeated and settled at score of 3.
- FRAX® tool assessment on admission indicating 12% probability of major osteoporosis and 4.6% probability of hip fracture over the next ten years.
- Falls decision tool completed on admission, scoring 'four ticks', and placed on the Falls CLIP.
- Preliminary Physiotherapy Assessment (PPA) on 20 April, identifying fully independent of movement, with no history of falls, indicating no need for further physiotherapy assessments. Recorded that she was taken off Falls CLIP on 22 April by Nurse Consultant.
- Various assessments by both her consultant psychiatrist and the clinical psychologist.

- POOL Activity Level (PAL) assessment completed on 29 April which identified that Maureen scored at the 'planned' level. The assessment noted that Maureen may be able to look in obvious places for objects, but that on five items on the assessment she scored at the 'exploratory level' and that some activities would need to be adapted if difficulties occurred.
- Assessment by the dietician on 5 May, which identified the aim of 'reducing weight loss' by offering high calorie diet with protein, fortified food and extra snacks.
- She was also seen on 5 May by the ward doctor after complaining of swollen legs, and was prescribed furosemide 20mg once a day for seven days.
- CPA meeting on 7 May with full attendance of MDT.
- A comprehensive psychological formulation, using the 'Columbo' model, undertaken on 11 May. This identified that Maureen needed meaningful activity and occupation, and to feel that those she cares about were safe. The formulation identified triggers for behaviour including; waking her up, tiredness and confusion, becoming agitated before visitors arrive, and depressed if they don't turn up, other people's visitors and chest and urinary tract infections. Recommendations included involving Maureen in ward based craft activities, getting her husband to phone up if unable to visit or likely to be late, and to spend quality time with husband in social activities. It was also identified that she experienced cramp in her feet and needed a review of her respiratory status, and for her husband to have more information on Alzheimer's disease.
- A ward based OT assessment was attempted on 14 May but Maureen declined to participate. This assessment would have used Large Allen Cognitive Level Screen (LACLS) tool.
- A successful home based OT assessment on 19 May.

Comment

- 5.4 We noted that there were gaps in the recording of some of the more routine assessments, such as daily fluid balance and the Food record chart.
- 5.5 We also noted that where the assessments indicated further assessment or intervention was required, this had not always happened. For example, there are at least 12 separate occasions when the EWS score was above 5. This should have required an urgent call to medical staff, hourly observations and application of oxygen therapy if hypoxia present. However, Maureen was only discussed with the medical team on two occasions, she didn't receive hourly observations until lower readings were obtained and it isn't recorded if she was given oxygen. Other areas that should have indicated further assessment or follow up include the elevated fasting blood glucose level of 6.6mmol/litre (normal level of 3 – 6 mmols/l) and the low Thyroid Stimulating Hormone (0.22 mmols/l where normal range was 0.35 – 5.5 mmols/l) from the initial blood tests on 22 April.

- 5.6 Despite the failed ward based OT assessment of 14 May, there was no record of further attempts at a ward based assessment before the home assessment on 19 May.
- 5.7 Alongside this, several of the assessments failed to consider all aspects of Maureen's medical history. This may not have been passed on verbally, but the information was recorded in the PARIS notes. For example, Maureen had a recent history of weight loss. The GP notes first noted this in 2014. The PARIS notes of 14 April 2015 then record reported weight loss from 6 stone 12 lbs (43.5kg) on 26 April to 6 stone 7lbs on 7 April, down to 6 stone 2 lbs (39kg) on 14 April.
This is a weight loss of 10 lbs or 4.5kg, more than 10% of her body weight. In addition to this, Maureen had had several episodes over the previous six months when she had been prescribed 30mg Prednisolone a day for a short period.
- 5.8 The Waterlow assessments of 19 April, 3 May and 17 May all score her at 5 or 6, a low risk of pressure ulcers. However, these assessments recorded Maureen being of average build when her BMI was 17.5, significantly below average.⁵² These assessments also did not factor in the unplanned weight loss of more than 10% of her body weight in recent months, the history of high doses steroids, and the impact of dementia causing a neurological deficit. Collected together these would have added at least an additional 15 points to her risk score, giving her a total score of 19 indicating significant risk of pressure ulcers. This is without including the later development of oedema in her legs. We have shown the more accurate scoring below.

Risk factor	Score
Sex	
Female	2
Age	
65 – 74	3
Build/Weight for Height (BMI=weight in Kg/height in m²)	
Below average – BMI < 20	3
Continence	
Complete/catheterised	0
Skin Type – Visual Risks Area	
Healthy	0
Mobility	
Fully mobile	0
Nutritional Element	
Unplanned weight loss in past 3-6 months < 5% Score 0; 5-10% Score 1; >10% Score 2	2
Special Risks – Tissue Malnutrition	
Smoking	1
Special Risks – Neurological Deficit	
Diabetes/ MS/ CVA/ motor/ sensory/ paraplegia Max 6	4
Special Risks – Surgery/Trauma	0
Special Risks – Medication	
Cytotoxic, anti-inflammatory, long term/high dose steroid Max 4	4
Total Score	19

⁵² A healthy BMI is considered between 20 – 25.

Table 1. Revised Waterlow assessment for Maureen

5.9 The FRAX[®] tool assessment completed on admission fails to assess correctly her risk of hip fracture, recording her ten year probability of a hip fracture as 4.6%. When we completed the assessment we arrived at a higher risk of fracture, at 14% and a 26% probability of major osteoporosis, as we included the low BMI. This assessment is shown below. If Maureen had been taking prednisolone for a longer period of time this would have markedly increased the risks to a risk of hip fracture of 25% and major osteoporosis of 39%.

The screenshot shows the FRAX tool interface. At the top, it indicates 'Country: UK' and 'Name/ID: G'. The questionnaire includes the following items:

- 1. Age (between 40 and 90 years) or Date of Birth: Age: 69, Y: , M: , D: .
- 2. Sex: Male Female
- 3. Weight (kg): 39.5
- 4. Height (cm): 149.5
- 5. Previous Fracture: No Yes
- 6. Parent Fractured Hip: No Yes
- 7. Current Smoking: No Yes
- 8. Glucocorticoids: No Yes
- 9. Rheumatoid arthritis: No Yes
- 10. Secondary osteoporosis: No Yes
- 11. Alcohol 3 or more units/day: No Yes
- 12. Femoral neck BMD (g/cm²): Select BMD [dropdown] [input] [Clear] [Calculate]

A red overlay displays the results:

BMI: 17.7
The ten year probability of fracture (%) without BMD

Major osteoporotic	26
Hip Fracture	14

View NOGG Guidance

Fig 1. Revised FRAX[®] tool assessment of Maureen

5.10 We acknowledge the Bone profile blood test results of 22 April indicating no abnormality of mineral assays, but suggest that further tests should have been used to determine whether or not treatment to reduce the risk of osteoporosis ought to have been commenced.⁵³

5.11 The MUST scores of 17, 19 and 26 April and 3, 10 and 17 May all score Maureen at 2, with a failure to record the unplanned weight loss. Whilst this did not prevent a referral to the dietician, the outcome of the dietician's assessment did not lead to a documented revised plan of care to address her weight loss, though the staff did take action to do so.

Recommendation 7:

The Trust should assure itself that assessments of risks in elderly patients are completed thoroughly and accurately, incorporating all aspects of relevant medical history, and which then lead to appropriate planned interventions to mitigate these risks.

Risk assessment and management of aggression

⁵³ From NICE CG 146 "Osteoporosis: assessing the risk of Osteoporosis: assessing the risk of fragility fracture" Clinical guideline Published: 8 August 2012 nice.org.uk/guidance/cg146

'Following risk assessment with FRAX (without a BMD value) or QFracture, consider measuring BMD with DXA in people whose fracture risk is in the region of an intervention threshold for a proposed treatment, and recalculate absolute risk using FRAX with the BMD value'.

- 5.12 FACE (OP) risk assessments were completed for Maureen prior to her admission on 13 April, and then a further three times on 17 April, 30 April and 9 May.
- 5.13 The FACE (OP) assessment of 17 April noted her impulsivity, agitation and recent history of hitting other people. She was noted to be at significant risk of violence to other people, with agitation and aggression, and severe self-neglect.
- 5.14 The assessment of 30 April records her recent distress and incident with F, and that she was at risk of harm from other patients and vulnerable, due to her interfering behaviours, and that she didn't understand situations due to her cognitive impairment. This also identified some significant risk to her health due to her chest condition.
- 5.15 A further update on 9 May recorded how she would become anxious and distressed and how her 'accelerated behaviours' placed her further at risk.
- 5.16 Following her admission on 17 April, there was an intervention plan recorded to maintain the safety of Maureen and others due to her history of verbal and physical aggression to staff and residents in the care home. This intervention plan included developing a therapeutic relationship with Maureen, staff to be aware of precipitating factors (such as having to stay in hospital), to ensure she received prescribed or as required medication, and to persuade her to participate in 1:1 activities to divert attention and thoughts if she became aggressive. It also says that during any episode, staff were to remain calm and approach with caution, possibly two staff, and eliminate the probable cause of her aggression from the area.
- 5.17 The formulation meeting of 11 May identifies her need for meaningful activity and to feel that those she cared about were safe. All the interventions identified were aimed at preventing or reducing any anxious or agitated episodes through activity and diversion. There is now new intervention to manage any aggression should it occur.
- 5.18 Although initially there were episodes of agitation and threatening behaviour, including the incident on 25 April with F, there are no records that Maureen was physically violent whilst on Picktree ward, except for the incident on 19 May where she 'brushed' F's cheek with her cardigan. We have found records that she was significantly agitated on five occasions, and was given 'as required' 0.5mg lorazepam on eight occasions. There are also frequent reports that she was restless and wandersome, though these diminish over the course of her admission.

Comment

- 5.19 We note again that the intervention plans used were only generally applicable in managing a violent incident, and that they were more specifically focussed on reducing or preventing Maureen's aggression and agitation, Though of course this is entirely appropriate, it would be helpful if intervention plans were to also include specific guidance on how to manage aggressive incidents.

Especially as in this case, whilst we understand the management of violence and aggression techniques are tailored to meet the needs of elderly people, Maureen was obviously quite frail, and any restraint would have needed very careful management.

5.20 As we have already made recommendations on this aspect of care we refer to this earlier recommendation here.

Care planning

5.21 We have covered in more detail the care planning to manage Maureen's aggression above. However, she also had intervention plans to cover:

- Sexual disinhibition;
- Vulnerability from others;
- Physiotherapy;
- Falls risk;
- Admission for assessment;
- General observations;
- Management of Section 2 MHA and her rights; and
- Physical and verbal aggression.

5.22 These were added to by further plans for her physical health relating to her COPD and the planned activity level identified from the POOL assessment on 6 May.

5.23 The formulation meeting on 11 May added further to her intervention plan, to which an additional plan of managing her detention under section 3 MHA was added on 17 May.

5.24 A further intervention plan was added on 20 May providing her with 1:1 observations due to her fractured neck of femur after she was pushed by F.

5.25 We have not found intervention plans to help manage Maureen's weight loss, despite frequent mention of this and an assessment by the dietician with a recommended plan of action to increase her weight. This appears at odds with the care provided, as the staff were monitoring Maureen's food and fluid intake, and encouraging her husband to bring in high calorie snacks. In fact they had managed to increase her weight by 3kg during her admission.

5.26 Aligned to this and the intervention plan for managing the risk of falls we would have expected further detail on the potential for mitigating the risk of a fall leading to serious injury/ fragility fracture in someone with such a low BMI. It would seem that the flawed assessments discussed earlier, allied with Maureen's independent mobility led to an underestimation of the likelihood of a fall leading to serious injury.

5.27 We have already made a recommendation on the need for accurate assessment leading to more robust care planning.

Comment

5.28 Maureen was emaciated with a low BMI and at much higher risk of hip fracture than initially thought. We would have expected a more robust assessment process that factored in her weight loss and recent prednisolone prescription. We would also have expected at least a consideration of other protective factors such as the use of hip protectors, although we acknowledge these are of marginal benefit.⁵⁴

5.29 However, any pharmacological intervention to reduce the risk of fracture would not have been given for long enough to be of benefit if commenced on the ward.

5.30 A more thorough assessment of the risk of osteoporosis should have taken place in the community before she was admitted to the care home. Although the community mental health team could have a role in identifying such a risk, the assessment process should have been initiated by the GP.

5.31 The Framework guidance for GMS contract 2014/15 recognises the pain, suffering, increased cost and mortality of fragility fractures, and rewarded GPs with QOF points for maintaining a register of patient with confirmed osteoporosis.⁵⁵

5.32 There is a note on the front page of Maureen's GP records that states:

“Reminder/ Alert: CONSIDER BIPHOS/CALCIUM IF HAD 3 OR MORE DOSES OF STEROIDS IN PAST YEAR”.

5.33 The NICE Guidelines state that assessment for the risk of fragility fracture should be considered for:

- all women aged 65 years and over and all men aged 75 years and over
- women aged under 65 years and men aged under 75 years in the presence of risk factors, for example:
 - previous fragility fracture
 - current use or frequent recent use of oral or systemic glucocorticoids

⁵⁴ “**Hip protectors.** Reported trials that have used individual patient randomisation have provided no evidence for the effectiveness of hip protectors to prevent fractures when offered to older people living in extended care settings or in their own homes. Data from cluster randomised trials provide some evidence that hip protectors are effective in the prevention of hip fractures in older people living in extended care settings who are considered at high risk.” NICE Guidance: *Falls in older people: assessing risk and prevention*. Clinical guideline [CG161] Published date: June 2013.

⁵⁵ The Quality and Outcomes Framework (QOF) rewards contractors for the provision of quality care and helps to standardise improvements in the delivery of primary medical services. The indicator is listed below.

“**OST004** The contractor establishes and maintains a register of patients:

1. Aged 50 or over and who have not attained the age of 75 with a record of a fragility fracture on or after 1 April 2012 and a diagnosis of osteoporosis confirmed on DXA scan, and
2. Aged 75 or over with a record of a fragility fracture on or after 1 April 2014 and a diagnosis of osteoporosis”.

- history of falls
 - family history of hip fracture
 - other causes of secondary osteoporosis⁵⁶
 - low body mass index (BMI) (less than 18.5 kg/m²)
 - smoking
 - alcohol intake of more than 14 units per week for women and more than 21 units per week for men.
- 5.34 It is not clear whether three or more doses of steroids means actual doses or prescriptions. Although we have seen the blood test results for bone profiles, indicating normal calcium levels, we have not seen evidence that Maureen was considered for further confirmatory testing of her bone mineral density to assess her risk of osteoporosis and fragility fracture, such as DXA scanning. Maureen was not prescribed bisphosphonates.⁵⁷
- 5.35 Nonetheless, Maureen had received high doses of a drug (prednisolone), known to increase the risk of osteoporosis, within six months prior to admission, and she also had other risk factors (low BMI, smoking, and COPD). For any treatment to have been effective it would need to have been started shortly after Maureen was prescribed prednisolone.

Recommendation 8:

NHS Durham Dales Easington & Sedgefield Clinical Commissioning Group and the Trust should work together to ensure that they fully implement the NICE Osteoporosis: assessing the risk of fragility fracture Clinical Guideline [CG146], correctly identifying all patients at risk of fragile fracture on respective caseloads.

Compliance with local policies, national guidance and relevant statutory obligations.

Safeguarding

- 5.36 A safeguarding alert was raised appropriately for Maureen after the first incident on 25 April with F, and also after the incident on 19 May.
- 5.37 Although there was a delay in raising the first alert (four days), these alerts seem to be entirely appropriate, and there are no indications that other alerts were needed.
- 5.38 We are pleased to note this practice was as required.

Mental Health Act

⁵⁶ The guidance provides a long list of secondary causes, one of which is chronic obstructive pulmonary disease.

⁵⁷ **Bisphosphonates** are a class of drugs that prevent the loss of bone mass, used to treat osteoporosis and similar diseases

- 5.39 On first reading, it appears odd that when Maureen's Section 2 MHA lapsed, she was assessed and then further detained under Section 3 MHA, despite being just a few weeks away from her planned discharge. She had already been assessed for NHS Continuing Healthcare Funding, but this assessment was not used, instead the requirements of aftercare planning under Section 117 MHA were used.
- 5.40 However, this is an entirely appropriate use of the Mental Health Act. The team needed time to work with her husband and to develop a suitable care package that would meet Maureen's needs when she went home. In all likelihood Maureen would not have been willing to stay in hospital informally. Because Maureen would have been non-compliant, the use of the Mental Capacity Act would not have been appropriate or lawful in such circumstances.⁵⁸
- 5.41 We are pleased to note this good practice.

Falls CLIP

- 5.42 We note that Maureen was appropriately placed on the Falls CLIP due to scoring 'four ticks' on assessment. She received a Preliminary Physiotherapy Assessment (PPA) on 20 April, identifying that she was fully independent of movement, with no history of falls, indicating no need for further physiotherapy assessments. It was recorded that she was taken off Falls CLIP on 22 April by Nurse Consultant.
- 5.43 The Falls CLIP requires that the assessment is completed within 12 hours of admission and reviewed weekly. After the initial assessment process this did not appear to have happened.

Behaviours that challenge CLIP

- 5.44 We have already noted that this was not in place on Picktree ward at that time, and that the Trust should roll this out across the MHSOP wards in the organisation.

6 Internal investigation and action plan

- 6.1 The Trust internal investigation was completed on 1 December 2015. It had the following terms of reference:
- To establish appropriateness of care or treatment delivered;
 - To look for improvements rather than to apportion blame;

⁵⁸ See AM V SLAM <http://www.bailii.org/uk/cases/UKUT/AAC/2013/365.html>

- To examine compliance with any relevant policies / procedures e.g. Care Programme Approach (CPA), Clinical Risk Assessment and Management (CRAM);
 - To identify any professional governance issues that need to be taken forward either operationally or through professional leadership;
 - To provide a report as a record of the review process, with documented findings;
 - To formulate an action plan to reduce or eliminate recurrence; and
 - To review care co-ordination issues, particularly in relation to the operational management of care co-ordination e.g. leave arrangements, case management, and supervision.
- 6.2 The internal investigation identified a wide range of contributory factors and made three recommendations:
- Lack of clarity of actions for addressing physical health care concerns;
 - Errors in recording of EWS; and
 - Maureen waiting for an unacceptable length of time on the floor after the incident, before the arrival of the ambulance.
- 6.3 We fully concur with these recommendations. In particular there was a lack of addressing the outcome of physical health assessments and interventions in relation to her COPD, and whilst there were errors arising from the initial EWS assessment, the actual protocol for escalation was also not followed.
- 6.4 The Trust has taken steps to address the prolonged waits for ambulances by patients after a fall.
- 6.5 However, we have identified further deficits in the care of F and Maureen that the internal investigation has not picked up.
- 6.6 Firstly, because the internal investigation has focussed on the care of Maureen and not considered the care of F, it does not provide the widest opportunity for learning lessons that can lead to improvements.
- 6.7 We were told that because Maureen had died and NHS England had decided the incident required an independent investigation the Trust was unable to investigate the care and treatment of F. It is not clear why this would be the case.
- 6.8 We identified several areas where F's care could have been improved, and which may have made a difference to the outcome of the incident. If addressed, these should lead to improvements in the care of similar patients, and a reduction in the recurrence of similar incidents.

- 6.9 These areas include implementing the Behaviours that Challenge pathway in MHSOP wards, updating policies when NICE guidance changes, and improvements to the management of violence and aggression including increasing incident reporting and more specific actions to be taken in the event of an incident.
- 6.10 We have also further identified aspects of Maureen's care that the internal investigation did not. Although the internal investigation identified communication between the MHSOP ward, mental health community staff and the care home, the information concerning Maureen's rapid weight loss either does not seem to have been understood or acted upon. There was no care plan to address this rapid weight loss, although staff were monitoring her food intake and actually helping her to gain weight. Further to this, other assessments did not seem to acknowledge the weight loss, or consider the risks this posed to Maureen's health.
- 6.11 Because of this there was no link made from a low BMI to the impact it had on her Waterlow, MUST and FRAX assessments and the potential for increased risk of harm. Consequently there was no mitigation or intervention plan in place for reducing the risk of fracture or increasing Maureen's weight arising from this.
- 6.12 The internal investigation terms of reference are quite general, which permits a degree of latitude. There is a reasonable consideration of some of the findings, and the action plan arising would improve some aspects of care for someone like Maureen, by improving physical health assessment and interventions and also the more accurate recording of EWS.
- 6.13 However we believe that the internal investigation was limited due to the lack of wider consideration of factors relevant to Maureen's care (low BMI and risk of fragility fracture) and the failure to consider F's care in general.
- 6.14 It therefore fails to meet the terms of reference, in particular because it is hard to see how improvements could be made to reduce recurrence without considering these issues, and therefore we feel the investigation fails to meet the requirement to look for improvements.
- 6.15 The internal investigation report does not comment on governance issues, nor does it comment upon the operational management of care coordination. However, we did not identify any findings or concerns in these areas.

Actions taken since the investigation

- 6.16 The Trust has provided an action plan update dated November 2016 on the progress made on the actions.
- 6.17 The actions identified in the internal investigation report were:
- All patients to have physical health reviews fortnightly with medical staff or physical health practitioner and this to be recorded in physical health care notes. Physical health review to take place at the point of any issues concerns raised by staff.

- All staff on the MHSOP wards to have EWS competency carried out by the Physical Health Care Nurse Consultant.
 - There have been delays in ambulances attending in-patients within mental health wards. This action is being addressed as a Trust-wide issue with the NEAS / Acute Trust
- 6.18 We have discussed progress on implementation of actions with the Nurse Consultant & Clinical Director for Mental Health Services for Older People, Durham and Darlington.
- 6.19 We have received the following information as evidence of completion of actions points 1, 2 and 3.
- 6.20 The physical health care practitioner reported that all wards were told that a patient needs a physical review at least every 2 weeks. This was agreed that it's not a full physical but an entry about physical health at least every 2 weeks is required. This could include review of blood results, review in MDT, or review in report out or review undertaken by the physical health care practitioner on a regular basis. We have not seen evidence that this is audited and are therefore unable to provide assurance that this action is complete.
- 6.21 The locality manager reported that all staff on Picktree ward were trained to properly use EWS, but now the ward has closed it is harder to evidence. All new starters are told that they have to do the course. EWS training was delivered to all staff from the ward by the manager.
- 6.22 We were told that EWS charts are audited weekly and gaps are addressed at a local level. There is also annual EWS audit completed by Physical Healthcare team. Trust wide EWS monitoring is being implemented as part of the Physical Healthcare CQUIN with a standard EWS template being used by all services, and regular audits completed. We have seen recent audits of the use and completion of EWS for Durham and North Yorkshire. We are assured that the Trust is regularly monitoring the correct use of EWS and taking steps to address any identified deficits.
- 6.23 We are also assured that further training does take place in the use of physical observations, which is delivered through the Trust training department.
- 6.24 The Trust has provided information on the actions taken to respond to the concerns on ambulance attendance times.
- 6.25 We have seen the SBARD (Situation, Background, Assessment, Recommendation and Decision) briefing note in Relation to In-patient requests for an ambulance for a fallen patient with a suspected or actual fractured neck of femur dated 12th April 2016. This details the following steps to be taken when calling for an ambulance:

“Report the location of the patient and then **immediately** inform the controller that we are **not an acute trust** but are a **mental health or learning disability facility.**”

- 6.26 The ward staff we spoke with were all able to explain in detail the steps they would now take, and how they would stress to the ambulance despatch team that the ward was not equipped to deal with emergencies and the patient would need to be blue lighted to A&E.
- 6.27 We have also seen the Learning Lessons bulletin (undated) on the serious incident/ fractured neck of femur which outlines the steps to be taken by staff following identification of a suspected fracture neck of femur.
- 6.28 We have seen the Acute Pain Guidance - Post Falls dated 28 July 2016 which provides clear guidance of steps to be taken in the event of discovery of a suspected fractured neck of femur including analgesia and positioning of the patient.
- 6.29 The Trust also provided us with the report from the Executive Director of Nursing to the Executive Management team on “Fractured Neck of Femur/Ambulance Response Times Report and Options Paper” dated 12 October 2016. This paper outlined the background to the problem of delayed response times and increased mortality of patient with fractured neck of femurs. The paper made recommendations that the Trust purchase specialist lifting equipment for patients that had fallen and had a suspected fracture. We have not seen the evidence that the Trust has purchased this equipment.
- 6.30 Because of the information the staff gave us on the actions they would now take and the reports and papers that have been issued within the Trust including reports to executive management team, enhanced guidance on management post fall, and the learning lessons bulletin we are assured that the Trust has dealt with this final action point.

7 Overall analysis and recommendations

- 7.1 The internal investigation by Tees, Esk & Wear Valleys NHS Foundation Trust identified three key areas of learning, which we fully support.
- 7.2 In addition to this we have expanded upon the internal investigation and made further recommendations to improve practice and for wider systems learning.
- 7.3 We believe the Trust internal investigation would have been improved by reviewing the care provided to F as well as Maureen, since the incident involved both of them, and there are learning points to be taken from our investigation of the care provided to F.
- 7.4 We also believe the Trust internal investigation did not identify gaps in the care provided to Maureen which it should have done, namely the

consideration of the impact of her low BMI within all of her assessments and her risk of osteoporosis.

- 7.5 We believe that the internal investigation conclusion, that there is no root cause of the death of Maureen is flawed. We believe that this internal investigation lacks the thoroughness to draw such a conclusion. Our investigation has identified opportunities for the Trust and the wider system to improve services for older people with aggression and those at risk of fragility fractures.
- 7.6 Since the independent review of deaths of people with a Learning Disability or Mental Health problem in contact with Southern Health NHS Foundation Trust⁵⁹ and more recently the CQC review of the way NHS trusts review and investigate the deaths of patients in England⁶⁰ providers (acute, community and mental health Trusts) must undertake a rigorous review of all unexpected deaths of patients in the care and to take action to prevent future premature deaths. These reports highlight that there is no inevitability about the unexpected death of someone with a learning disability or mental health problem, however frail they are. We therefore make one final recommendation.

Recommendation 9:

NHS Durham Dales, Sedgefield and Easington CCG, NHS North Durham CCG, Tees, Esk & Wear Valleys NHS Foundation Trust, County Durham and Darlington NHS Foundation Trust and North East Ambulance Service should regularly and collectively review all deaths of patients transferred from MHSOP wards to A&E with suspected fragility fractures to fully identify opportunities for system improvements to reduce premature deaths.

Predictability and preventability

- 7.7 We are asked to provide a view in such investigations on whether the incident that led to the death of Maureen was predictable or preventable.
- 7.8 Predictability is ‘the quality of being regarded as likely to happen, as behaviour or an event’.⁶¹ An essential characteristic of risk assessments is that they involve estimating a probability. If a homicide is judged to have been predictable, it means that the probability of violence, at that time, was high enough to warrant action by professionals to try to avert it.⁶²

⁵⁹ NHS England. “Independent review of deaths of people with a Learning Disability or Mental Health problem in contact with Southern Health NHS Foundation Trust April 2011 to March 2015”. December 2015. <https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2015/12/mazars-rep.pdf>

⁶⁰ Care Quality Commission “*Learning, candour and accountability A review of the way NHS trusts review and investigate the deaths of patients in England*” December 2016 <http://www.cqc.org.uk/sites/default/files/20161213-learning-candour-accountability-full-report.pdf>

⁶¹ <http://dictionary.reference.com/browse/predictability>

⁶² Munro E, Rungay J, Role of risk assessment in reducing homicides by people with mental illness. The British Journal of Psychiatry (2000)176: 116-120

7.9 Prevention⁶³ means to 'stop or hinder something from happening, especially by advance planning or action' and implies 'anticipatory counteraction'; therefore for a homicide to have been preventable, there would have to be the knowledge, legal means and opportunity to stop the incident from occurring.

7.10 In considering these we have asked two key questions:

- Was it reasonable to have expected those caring for F and Maureen to have taken more proactive steps to manage the risks presented by them?
- Did they take reasonable steps to manage these known risks?

Was the death of Maureen predictable?

7.11 We have reviewed the care provided to both F and Maureen. We consider that F was known to be predictably unpredictable. When he was placed on EVO there was a notable reduction in incidents, possibly because there were staff on hand to defuse any incidents before they escalated. We believe that it was premature to take him off EVO. The formulation meeting identified the triggers for his aggressive responses. We noted that the incident on 19 May was provoked by Maureen and F retaliated. Even though a member of staff was on hand they were unable to prevent him from pushing Maureen which led to her fall.

7.12 Although we believe it was predictable that F would be involved in an altercation with someone, it was not predictable that this would be Maureen, or lead to her death.

Was the death of Maureen preventable?

7.13 We have considered the following points:

- F was known to be predictably unpredictable and aggressive, particularly when retaliating;
- Maureen was inadequately assessed for risk of fragility fracture, and mitigation was not put in place soon enough; and
- After her fall, Maureen then spent an inappropriate amount of time lying on the floor whilst waiting for an ambulance. It is known that for people with COPD, lying flat reduces lung function and increases the risk of acquiring a chest infection.

7.14 Actions taken which may have lessened the risk of harm arising include:

- More appropriate intervention planning to deal with F's retaliation when provoked (based on previous behaviours) may have prevented the retaliatory pushing over of Maureen;
- Earlier consideration of the risk of Maureen's osteoporosis and treatment of this whilst in the community may have lessened the likelihood of fracture;

⁶³ <http://www.thefreedictionary.com/prevent>

- More rigorous assessment on admission for Maureen, with robust physical health interventions, based on accurate history taking and assessment might have improved her physical care; and
- Consideration of her risk of fragility fracture based on accurate assessment of BMI, and possible use of hip protectors may also have prevented Maureen fracturing her neck of femur.

7.15 Because of these issues, we believe that the death of Maureen was caused by several contributory factors all coalescing at the same time, and that it was preventable.

Table of Recommendations

Recommendation 1:

The Trust should assure itself that the findings and observations of patients when admitted to MHSOP wards leads to accurate care planning and appropriate interventions.

Recommendation 2.

The Trust should review management of aggression guidance and the clinical link pathway for Behaviours that Challenge in Mental Health Services for Older People wards to ensure that explicit guidance in how to manage an incident is an outcome of the assessment process and is included in intervention plans.

Recommendation 3:

The Trust should ensure that MHSOP wards fully comply with the policy on recording observations.

Recommendation 4:

The Trust should ensure that all relevant policies and procedures are updated whenever new guidance from NICE is issued.

Recommendation 5:

The Trust should develop a programme of increased awareness of the need to accurately report incidents with the MHSOP wards, and assure itself that incidents are being accurately reported.

Recommendation 6:

The Trust should assure itself that MHSOP wards are now following its own best practice guidance with regards to Behaviours that Challenge in dementia.

Recommendation 7:

The Trust should assure itself that assessments of risks in elderly patients are completed thoroughly and accurately, incorporating all aspects of relevant medical history, and which then lead to appropriate interventions to mitigate these risks.

Recommendation 8:

NHS Durham Dales Easington & Sedgefield Clinical Commissioning Group and the Trust should work together to ensure that they fully implement the NICE Clinical guideline [CG146], Osteoporosis: assessing the risk of fragility

fracture correctly identifying all patients at risk of fragile fracture on respective caseloads.

Recommendation 9:

NHS Durham Dales, Sedgefield and Easington CCG, NHS North Durham CCG, Tees, Esk & Wear Valleys NHS Foundation Trust, County Durham and Darlington NHS Foundation Trust and North East Ambulance Service should regularly and collectively review all deaths of patients transferred from MHSOP wards to A&E with suspected fragility fractures to fully identify opportunities for system improvements to reduce premature deaths.

Appendix A – Terms of reference

Terms of Reference for Independent Investigations in accordance with NHS England's Serious Incident Framework 2015 Appendix 1

The individual Terms of Reference for independent investigation 2015/3066 are set by NHS England North. These terms of reference will be developed further in collaboration with the offeror, and family members.

However the following terms of reference will apply in the first instance:

Core Terms of Reference

Review the Trust's internal investigation of the incident to include timeliness and methodology to identify:

- If the internal investigation satisfied the terms of reference;
- If all key issues and lessons were identified;
- If recommendations are appropriate and comprehensive;
- The implementation of the internal action plan through evidence; and
- If the affected families were appropriately engaged with.

Following a desk top review of the internal report, identify gaps and additional key lines of enquiry required

Assist the Trust to expand the internal report to consider the perpetrator as a patient where required, in doing so;

Review the appropriateness of the treatment of the service user (victim) in the light of any identified health and social care needs, identifying both areas of good practice and areas of concern including any areas of future risk.

Review the adequacy of risk assessments and subsequent risk management, specifically the communication of risk information (including safeguarding) and plans for mitigation.

Review and assess the Trusts compliance with local policies, national guidance and relevant statutory obligations.

Establish contact with both the families of those affected as fully as is considered appropriate, in liaison with the Provider.

Determine through reasoned argument the extent to which this incident was either predictable or preventable, providing a detailed rationale for the judgement.

Provide a written investigative report to NHS England North that includes measurable and sustainable recommendations.

Based on overall investigative findings, constructively review any gaps in service provision to both perpetrator and victim, identify opportunities for improvement.

Assist NHS England in undertaking a brief post investigation evaluation.

Supplemental to Core Terms of Reference

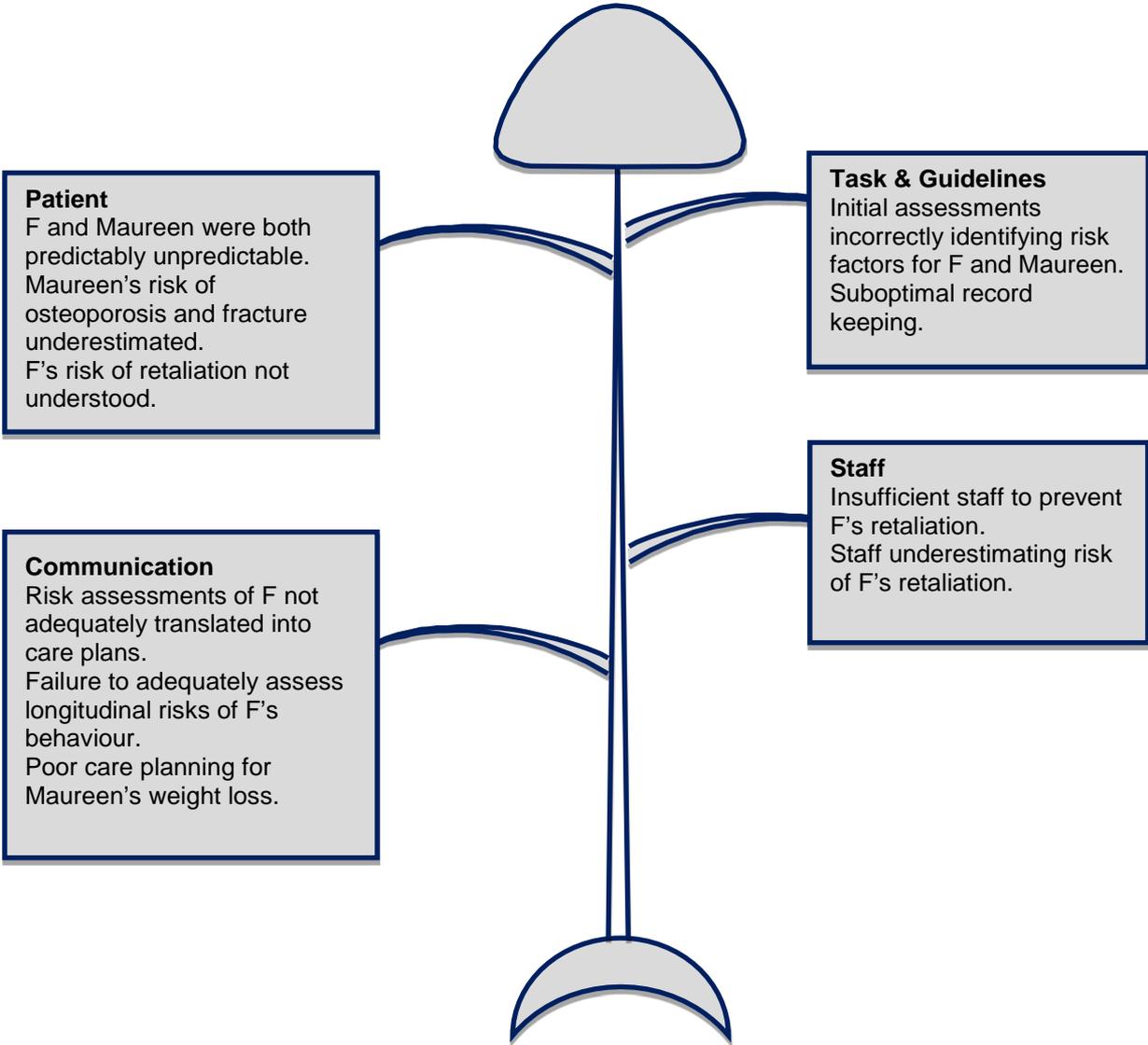
Conduct an evidence based review of internal report recommendations to confirm they have been fully implemented.

Support the Trust to develop an outcome based action plan based on investigation findings and recommendations.

Support the commissioners (North Durham CCG) to develop a structured plan to review implementation of the action plan. This should include a proposal for identifying measurable change and be comprehensible to service users, carers, victims and others with a legitimate interest.

Within 12 months conduct an assessment on the implementation of the Trusts action plans in conjunction with the CGG and Trust and feedback the outcome of the assessment to NHS England North.

Appendix B – Fishbone analysis



Appendix C - Chronology of F's care from admission to 20 May 2015

These chronologies have been drawn up from the medical record and clinical notes of F and Maureen. The chronology only covers the period of their last admission to Picktree Ward up to the incident on 19 May 2015.

F's admission chronology⁶⁴

Date	Detail
	<p>F was being cared for in Jack Dormand Care Home, Peterlee, County Durham. His wife was also cared for in the residential care part of the facility. They had both been there for the last six months.</p> <p>He had first presented with cognitive impairment to Mental Health Services for Older People (MHSOP) in 2006. He was referred again to MHSOP by his GP in 2009, scoring 23/ 30 on a Mini Mental State Examination. He was diagnosed with dementia in 2012 and had lived at home with his wife until November 2014.</p> <p>He had a recent history of unpredictable aggressive behaviour, with some agitation.</p>
<p>7 April 2015 4.00pm</p>	<p>The community psychiatric nurse (CPN) had been asked to call in urgently to assess F, as the care home felt they could no longer manage him due to his unpredictable behaviour. When initially placed in the care home he had responded to Risperidone and been more settled, but this had recently changed. The CPN had discussed a medication change with the consultant psychiatrist before visiting the assessment. The consultant psychiatrist had agreed that a small dose of Carbamazepine might be helpful to reduce the aggressive and unsettled behaviour.</p> <p>On the visit of the CPN, F appeared unsettled. He told her that he was very unhappy and wanted to die, and that he felt like a prisoner. He was disoriented in time, date and place, and was unable to recognise the care home staff or the CPN even though he had met her on several previous occasions.</p> <p>It was reported that F had hit a member of staff, hit a drugs trolley and pulled a radiator off the wall. He was reported to be targeting male members of staff.</p> <p>There was no evidence of aggression during the assessment, but the care home staff reported they were afraid of him. Although a change in medication was offered the care home staff refused to try it as they felt it would not be effective.</p> <p>Based on this assessment the CPN requested a MHA assessment.</p>

⁶⁴ Obtained from the clinical notes. Most of the times noted are the time of the entry in the notes, not the time of the event. Where a significant event is timed and recorded we have identified this, such as the admission time.

<p>7 April 2015 8.36pm</p>	<p>MHA assessment completed by Approved Mental Health Practitioner and two section 12 doctors. Although noted to be more settled than on previous visits, he was noted to be dysphasic, and more disoriented. History of dementia and behaviour that challenges, with verbal agitation and sometimes physical aggression. Both he and wife had been resident in Jack Dormand care home for the last six months. F in the locked EMI (Elderly Mental Ill) residential wing, and his wife in the standard residential care facility. His wife had also been reported as drinking to excess, which had exacerbated the situation with F as he got frustrated with his wife.</p> <p>Medical report notes reports of increasing agitation: dismantled radiator, punched drug trolley, punched a female member of staff, and attempted to punch another. F has a background in martial arts, and can be intimidated by larger men.</p> <p>Because of the escalation in his behaviour, and the failure of the care home to manage his needs it was agreed F needed admission to a mental health ward under section 2 of the MHA.</p> <p>Medication on admission: Risperidone 500 mcg morning and night Atorvastatin 10mg at night Aspirin dispersible 75 mg daily Lansoprazole 30mg daily Tamsulosin m/r 400mcg daily Memantine 20 mg daily GTN spray as required</p>
<p>11.25pm</p>	<p>F was admitted to Ceddesfield Ward, Auckland Park Hospital at 10.15pm accompanied by AMHP and senior care worker from care home. Admission SOAP⁶⁵ completed. Baseline observations completed, physical assessment noted reduced airway entry in his lung, suggestive of fluid. Early Warning Score = 0; Glasgow Coma scale = 14. Falls tool assessment scored 1 tick for agitation / confusion, but admitting nurse decided he did not need to be on Falls CLIP (Clinical Pathway) as no previous history of falls. Observations completed and recorded.</p>
<p>7 and 8 April Night</p>	<p>Admission by on call doctor at 0.34am Noted to have significant cognitive impairment, disoriented to time and place, and poor concentration. Scored 0/10 on Adult Memory Test Score (AMTS). Plan was for continued further physical assessments (blood tests, urine for C & S, Chest X-ray, ECG and general observations on the ward. F settled through the night, but not slept much, awake until 3.45 am, then from 5.30am.</p>

⁶⁵ A method of constructing an assessment process under the headings of: Subjective, Objective, Assessment and Plan.

8 April Morning	<p>Hip decision support tool completed, amber and red scored, for physio assessment on 9 April.</p> <p>Section 17 leave form completed for visit to general hospital for X ray</p> <p>Bedroom door key issued to F, though observed on several occasions trying to open other doors. Observations recorded approximately hourly.</p> <p>Telephone contact with nephew (closets relative) confirming first point of contact. Referral for Independent Mental Health Advocacy sent. AMHP report received.</p> <p>Daily SOAP completed. Observations recorded approximately hourly.</p> <p>Preliminary physiotherapy assessment: Problem Oriented Assessment of Mobility (POAM) score of 27/ 28 indicating low risk of falls. Not necessary to place on Falls CLIP due to low risk of falls, removed from physio caseload. Admission bloods obtained. ECG obtained.</p> <p>Discussed in ward round. For general observations, admission assessments and all tests (blood/ x-ray, urine) to be completed.</p> <p>Attended Bishop Auckland General Hospital for Chest X ray.</p>
Afternoon	<p>Settled on the ward, completed personal history profile with nursing staff. Presented as pleasant and settled, if confused.</p> <p>Reviewed by speciality doctor. Disorientation noted, very poor short term memory. Plan, monitor mood, complete tests. Not aware of aggression leading to admission.</p> <p>Daily SOAP completed. Assessment noted ECG completed, all admission bloods taken and chest X-ray completed.</p>
Evening	<p>Settled afternoon and early evening, but frequently asking staff to go home, and unable to retain rational discussion and reason for staying. Becoming agitated, so given as required (PRN) Promethazine 25mg at 6.50pm.</p>
8 and 9 April Night	<p>Sat in lounge at handover, then asleep, Awoken by staff, accepted medication and retired to bed.</p>
9 April Day	<p>Change in care coordinator</p> <p>Ward round: - to arrange admission meeting and formulation meeting on 20 April, monitor behaviour. Obtain old case notes</p> <p>Rights regarding detention under S2 MHA read to F. F not able to understand.</p> <p>Medicines reconciliation completed by pharmacist.</p> <p>Reviewed by speciality doctor. Awaiting test results. Daily SOAP completed. Phone call received from F's sister.</p>
9 and 10 April Night	<p>Asleep in lounge at commencement of night shift, awoken and assisted to bed at 11pm. Slept through the night apart from up once for toilet.</p>

10 April Day	Ward round. Plan as before. Niece contacted, who was happy to be first point of contact for arranging meetings etc. Planning to visit next week. Assessed and reviewed by Nurse Consultant. Blood results returned, no abnormalities detected. Low falls risk. Slightly constipated, and prescribed Movicol. Complaining of dizziness, very apparent when standing from sitting, For daily lying and standing blood pressure observations. F wanting more to drink, so for jug of fluid in his room each day. Bed now available on Picktree ward, transfer arranged for that afternoon. Niece informed of transfer. Also noted to prolonged QT interval, since Risperidone increased in March, so for repeat ECG. ⁶⁶
Afternoon 3.57pm	Transferred to Picktree Ward, Lanchester Road Hospital, Durham. Bedroom allocated and named nurse. Given key to his room. Nursed on general observations. Requirement for ECG transferred. U's and E's negative.
10 and 11 April Night	Accepted medication and supper. Retired to bed at 11.00pm, slept until 3.00am. Wandered around the ward a little, asking staff where he was, but accepted reassurance that he was in hospital.
11 April Afternoon	Rights read under S2 of MHA read to F. F stated he was happy to stay, aware that he was in hospital, due to problems with his memory, and stated 'whatever the doctor thinks, I'm not a rebel'. Staff spoke to niece. Informed that he had settled onto Picktree. Not displayed any aggression. Admission meeting still to be arranged. Daily SOAP completed. Unpredictable behaviour noted. ECG to be redone.
11 and 12 April Night	Spent early evening with other patients. Disoriented to place, unable to retain explanation, accepted night medication and retired but refused to get undressed for bed. But slept through the night.
12 April Day	Daily SOAP. F wanting a taxi to go home. Given explanation of detention under MHA. F became angry, threatened to smash the place up, and picked up table and threw it to the floor. Given as required Lorazepam, settled down afterwards.
12 and 13 April Night	Confused and disoriented, asking to be taken to Wheatley Hill (where he used to live). Accepted medication, retired to his room, but refusing to put night attire on, eventually asleep after 'pottering in his drawers' and placing a chair in front of his door.
13 April Morning 11.48am	Daily SOAP. Received preliminary physiotherapy assessment. No further assessment of mobility required. Phone call received from staff at care home on behalf of F's wife asking about F, and if she could visit. Visiting times offered.
Afternoon	Settled afternoon, talking about his life with support worker. Was coherent but disoriented, and would lose track of conversation. Able to recall being a pilot, and that he liked to keep fit, and did judo and boxing. Daily SOAP completed. Noted to be settled. Repeat ECG noted.

⁶⁶ Long QT syndrome is a heart rhythm disorder that can potentially cause fast, chaotic heartbeats. These rapid heartbeats may trigger a sudden fainting spell or seizure. It can be a side effect of antipsychotic medication, like Risperidone.

	Admission meeting provisionally arranged for 23 April.
13 and 14 April Night	Accepted night time medication, returned to his room, went to bed with clothes on. Came out of the room in the nights, stated he had scratched his bottom. Found to be bleeding on buttock, Dry dressing applied to reddened area, for review next day. Otherwise slept well, apart from up for toilet.
14 April Morning	Ward round. Consultant psychiatrist review. Circumstance leading admission discussed. Formulation meeting to be arranged, and family meeting on 23 April. Wanted to see his wife, and visit arranged for next day. Daily SOAP completed. Unpredictable aggression noted.
14 and 15 April Night	Retired to his room after night medication. Refused to undress day clothes. Appeared to have slept through the night.
15 April Morning	Report Out / ward round. Formulation meeting to be arranged for 23 April, and doctor to review today. Reddened area identified as psoriasis by foundation doctor
Afternoon	Noted to be disoriented to time and place. Daily SOAP noted F to be settled throughout the day.
15 and 16 April Night	Initially low in mood, though pleasant at start of night shift. Retired to bed though refused to undress.
16 April Day	Consultant psychiatrist review with members of the ward team. Medication change would not benefit F, but may need care home change as they can't cope with his behaviour. Summary of review and previous history in notes from consultant psychiatrist. History of unpredictable aggression noted. No recent physical aggression noted, though verbal aggression on a few occasions reported. Noted to lack capacity to give consent for investigation and treatment. Unable to remember being visited by wife on previous day. Stated he believed his wife had died a year ago. Daily SOAP completed,
16 and 17 April Night	Falls decision tool completed, scored 3 (1 for agitation, 1 for or more prescribed medication and for restless at night) Falls CLIP commenced. Some confusion early in the evening, with wandering. Settled night, but slept in day clothes despite encouragement to change
17 April Morning	Discussed in ward with MDT, Settled on ward with no signs of aggression.
Afternoon	Daily SOAP – participated in activities, but relatively settled, refused medications. Confused and disoriented. Received 1-1 time with support worker. Falls referral sent to OT. For falls assessment on 24 April. Telephone message on niece's answerphone arranging formulation meeting on 23 April at 2.30pm.
17 and 18 April Night	Settled night, but again refusing to change into night clothes.
18 April Morning	Nephew confirmed attendance at CPA meeting on 23 April.

Afternoon	Daily SOAP. Remains pleasant and settled with disorientation.
Evening	EWS completed – scored 0, but blood glucose result was 12.4 mmols. Plan for staff to monitor.
18 and 19 April Night	Settled evening. Accepted medication, and changed into night clothes
19 April Day	Family contact with wife and niece confirming attendance at admission meeting on Thursday (23 April) Daily SOAP. Settled, visited by wife and niece. Analysis – no change to current risks. Weight increased to 55.7kg
19 and 20 April Night	Pleasant and friendly, noted to have put some weight on, and taking good diet and fluids. Accepted medication, and retired, though refused to change into night clothes
20 April Day	Ward round with MDT. Noted to be much more settled on ward.
11.00am:	OT assessment – in patient falls screen. Large Allen Cognitive Level Screen (LACLS) score 3.6. Noted to have limited concentration span, be easily confused. Summary identified that although falls were self-reported, no evidence of same. Disoriented to time and place. Needing minimal supervision with self-care activities. No interventions implemented as a result of assessment.
Afternoon	Phone call from nursing home manager, who wanted to make sure that ward was aware that F wasn't only aggressive if his wife had been drinking but that he could be aggressive at other times. This was to be discussed in the ward meeting next week. F was unsettled in the ward, and found in another patients room, very confused. But able to recall the visit from his wife. Later settled, but wanting to go home. Daily SOAP.
Evening	F anxious and stated he missed his wife.
20 and 21 April Night	Quiet at start of the evening, refused medications and night time drink. Not slept well over night, barely 2 hours
21 April Day	Ward round with MDT. Noted to be wanting to go home to his wife, refusing medication. One report of grabbing a nurses wrists, but no other reports of aggression.
Afternoon	Daily SOAP. Continue with current plans and discuss in formulation meeting.
21 and 22 April Night	Refused supper and became angry, demanding everyone leave his property. Became more agitated when staff tried to orientate him. Threw a cup of tea at a member of staff, then hit member of staff on hand with cup. Became more aggressive, using judo 'moves'. Required hand held restraint, and given as required Lorazepam 0.5mg. Then later settled and slept well.
22 April	Discussed in ward meeting. Last night's events recounted, and use of restraint. Datix form completed. Daily SOAP completed still requiring pharmacy review. For admission meeting on 23 April. Falls intervention plan completed.
22 and 23 April Night	Settled evening and night, pleasant and amenable. Took supper and evening drink. Refused to change into pyjamas, but appeared to have slept well.

23 April Day	10.25am Psychology session by assistant psychologist. No further risks identified.
2.00pm	Admission meeting, with consultant psychiatrist, nurse in charge of ward, manager and named nurse from nursing home, nephew and niece, F's wife, social worker, advocate and community psychiatric nurse. Agreed that F would not go back to Jack Dormand nursing home, and that wife would look for another home that could care for them both.
4.45pm	CPA meeting. Discussed F's agitation and aggression, and threatening behaviour to staff and residents, and how he can get angry with his wife. Plan was for Social worker to help his wife find them both suitable placement with more space for F to wander. Discussed need for possible Section 3 if placement not found before Section 2 expires.
Afternoon	Daily SOAP. Plan for 24 hour care.
23 and 24 April Night	Settled evening and night, but still sleeping in day clothes,
24 April Morning	Ward round. Jack Dormand nursing home has agreed they would take him back.
Afternoon	Daily SOAP. EWS noted to 1 (temperature of 36 degrees). Clinical psychologist formulation completed.
24 and 25 April Night	Settled evening and night, accepted medication but refused to change into night attire.
25 April Afternoon	Maureen was heard to scream, and staff found her to be extremely agitated, invading F's personal space in corridor, with F holding up a walking stick, with Maureen shouting at him. Maureen said that F had hit her on the arm with the stick, which F denied. Maureen checked for injury but none found. Datix completed. Daily SOAP. Reported that he had been settled. Mood noted to be agitated due to other patients shouting. Rights under Section 2 MHA read to him.
25 and 26 April Night	Settled night, accepted medications.
26 April	Daily SOAP, settled but confused at times. Interacting with staff and enjoying activities, EWS score = 0.
26 April 6.45pm	Altercation with another patient. Staff found F standing over another patient attempting to bite at their face, making growling noises. Staff had to physically remove F. F stated the other patient had been attacking him, but history not corroborated by staff witnesses. Placed on Enhanced Visual Observations (EVO).
26 and 27 April Night	Settled evening and night, accepted medications, retired to bed.
27 April Morning	Ward round review with MDT. Aggressive incident of previous day noted. Family to be informed of incident. Social worker to continue looking for new facility for F and his wife.
Afternoon	Formulation meeting with F's wife, niece and nephew, consultant psychiatrist, care coordinator, staff nurse, additional consultant psychiatrist, social worker, carer from nursing home, clinical psychologist and assistant psychologist. Formulation based on

	<p>Columbo model.⁶⁷</p> <p>This identified that F needed to be taken seriously, and treated with respect. He liked to talk to women, and could be charming and gentlemanly. He liked to feel useful, but could find larger men intimidating. The formulation identified triggers for behaviour (people bigger than him, separation from his wife, bad language, someone standing over him). Recommendations were to treat F with respect, be aware he may find larger men intimidating, that F usually responded better to women, take him seriously, provide open environment with space.</p> <p>Daily SOAP completed. Remains on Enhanced Visual Observations</p>
27 and 28 April Night	Settled night.
28 April Morning	Ward round with MDT, Consultant psychiatrist present. Recent deterioration in behaviour and aggressive episodes noted. S117/ CPA meeting required to consider future care needs and placement. Liked to look after his wife, but could no longer make decisions which caused further stresses. Medication changed – stopped night dose of Risperidone 500mcg, to start Carbamazepine 100mg.
Evening	Safeguarding link alerted to incident of aggression. Safeguarding link happy with actions taken, but advised ward to contact county safeguarding team.
28 and 29 April Night	Settled night, slept in his day clothes. EVO maintained.
29 April	Ward round with MDT. No changes noted, remains on EVO, EWS score = 0.
6.40pm	Patient E stopped in front of F, and said something, then slapped F across the cheek. Staff member intervened, but whilst they had their back to F he retaliated and punched E in the face, further staff intervention and separation of patients. Datix form completed.
29 and 30 April Night.	Settled night, accepted medication. Appeared to have slept well, Reported to remain on EVO through the night.
30 April Morning	Ward round with MDT. Altercation between E and F discussed, for safeguarding to be informed and arrange MHA assessment.
Afternoon	<p>Safeguarding informed and alert raised. F to remain on EVO. TEWV safeguarding advised to update FACE risk assessment. TO monitor the situation, and if the incidents are recurring then there may be a need to move F from Picktree ward.</p> <p>F's wife informed of the incident.</p>

⁶⁷ The Columbo model is a needs led formulation based framework to make sense of behaviour that challenges services.

	Daily SOAP completed – no change noted. Continue on EVO
4.25pm	Entry from consultant psychiatrist. Noted that F remained unpredictable, with recent history of punching one patient, and jumping on top of another. Lack of insight recorded, and also lack of mental capacity. Application to detain under section 3 made.
30 April and 1 May Night	Settled evening / night. Declined to change into pyjamas.
1 May Morning	Ward round with MDT. Staff informed of recent incident. Section 117 meeting to be arranged. 11.27am. Rights under Section 3 read, but appeared to have limited understanding of the reasons for his admission and detention.
Afternoon	Daily SOAP. No change.
1 and 2 May Night	Initially quiet, became more unsettled through the evening. Retired to his bedroom, but couldn't settle, repeatedly locking and unlocking his door. Unable to express what was wrong, eventually sat with staff and had a drink. Retired at 2.00am. Refused to change into night attire.
2 May Morning	Daily SOAP noted remains on EVO, with no further symptoms
Afternoon	1.34pm Attempt made to read F his rights under Section 3 MHA, but showed little understanding. Allocated IMHA.
Evening	Stated he felt dizzy, appeared pal. EWS completed, score = m0. Blood sugar taken, 5.4 mmols. Requested to lie on his bed.
2 and 3 May Night	Settled evening, took supper and drink. Eventually persuaded to change into night clothes. Remains on EVO
3 May	Daily SOAP. Nil to report
3 and 4 May Night	Settled evening and night. Refused to change into night attire.
4 May	Settled day. Continues on EVO. Visited by his family. Family concerned about future placement.
4 and 5 May Night	Accepted supper but refused some of his medication, spitting it out. Eventually went to bed, and slept from 0.30am.
5 May Morning	Ward round with MDT. Noted to have been on EVO. Care home not keen to take him back due to behaviour. Plan for general observations, to be increased according to needs. Section 117 meeting to be arranged.
Afternoon	Participating in group activities, Following simple instructions, appeared to have poor motivation.

	Pool Activity Level (PAL) ⁶⁸ completed. F scored at the planned level. Assessment noted that F may be able to look in obvious places for objects, that he couldn't understand complex sentences, and that the care giver may need to solve problems that arise for him. Daily SOAP noted nothing to report.
5 and 6 May Night	Initially settled, becoming a little disquieted, asking why he was being kept there. Accepted explanations and settled soon after. Refused to change into his pyjamas. Accepted all medication.
6 May Morning	Ward round with MDT. No behavioural management issues noted, but disgruntled mood observed. Future placement to be discussed. Attended Physiotherapy group. Daily SOAP. EWS = 0
5.25pm	F approached fellow patient D who was sat eating. F picked up D's stick, who reached out to stop F taking it. F struck D on the right arm with the stick. Staff intervened, blocking another attempt to hit D from F. F escorted away from D. F placed on EVO. Safeguarding to be contacted. F stated he felt in danger, but did not want to commit suicide. Then later stated 'all bets are off'.
6 and 7 May Night	Settled evening, accepted medication and evening drink, retired early.
7 May Day	Ward round with MDT. Continues to be unpredictable, but observations regraded to general. Daily SOAP reported settled in mood. Appeared to brighten after visit from his wife, but had forgotten about visit shortly after. EWS score = 0. IMHA updated on recent plans, asked to be kept informed of discharge arrangements.
7 and 8 May Night	Settled evening, though a little anxious. Retired to bed, but slept in chair.
8 May	Ward round with MDT. Remains confused and disoriented on general observations.
Afternoon	Telephone call from F's sister to medical secretary, who was quite irate and stated she wanted to take F home to live with her and her husband. Explained that she could not and to contact F's wife to discuss this. Consultant psychiatrist informed of phone call. Daily SOAP, nil of note.
Evening	F in his room, stated he felt low. Stated he was keeping negative thoughts away as he had a loving wife, and family. F said he needed to be strong as he had always been 'the provider'. Time spent with F offering reassurance, which he appreciated.
8 and 9 May Night	Settled evening and night.

⁶⁸ The Pool Activity Level (PAL) Instrument is widely used as the framework for providing activity-based care for people with cognitive impairments, including dementia. The Instrument is recommended for daily living skills training and activity planning in the National Institute for Clinical Excellence Clinical Guidelines for Dementia.

9 May	<p>Daily SOAP. Refused offers of bath, encouragement with self-care required. No aggression noted.</p> <p>Staff nurse spent time with F, explaining his rights under Section 3 MHA. Stated he will stay in hospital until doctor says he can leave, but that he misses his wife. Appeared to have limited understanding.</p>
9 and 10 May Night	Settled evening and night, appeared to have slept through the night.
10 May	Daily SOAP. Little to note, appeared settled, but asleep quite a lot on and off through the day. Minimal interaction with patients and staff. EWS completed, score = 0.
10 and 11 May Night	Pleasant and interacting with staff in the evening, talking about his wife and how long they had been together. Accepted medication but refused to get undressed.
11 May	Referred to podiatry. IMHA contacted ward to say she couldn't attend Section 117 meeting on 14 May, but wanted to pass on the F had said he wanted to be with his wife, wherever that was. Also that the social worker was supporting his wife to find somewhere for both of them to stay. Initially disoriented, described himself as feeling desperate. Stated he had felt low in the morning, and was quite confused in the afternoon. Disoriented in time and place. Joined in ward activities and became more animated.
Afternoon	Daily SOAP. Nile of note to report. Section 117 meeting arranged for 14 May at 1pm/2pm.
11 and 12 May Night	F didn't sleep all night, remained subdued, and anxious over not seeing his wife. Reported to be pacing the floors, and irritable with staff. Not amenable to reason, believed the ward was his betting shop. More settled from 4.45am, but refused to retire to bed.
12 May	<p>Ward round with MDT. Continue with medication as prescribed.</p> <p>Daily SOAP. Noted to be lacking concentration and motivation, not joining in groups.</p> <p>Jack Dormand care home contacted, confirmed that F's niece will be bringing his wife to the Section 117 meeting. Social worker also contacted, who confirmed they had provided a list of homes for F and his wife. F's niece stated that she and her aunt had seen one of these (Yoden Hall) but no decision on the outcome.</p>
12 and 13 May Night	Appeared low in mood, told staff he wanted to go home to his wife. Accepted his night medication, including 25mg Promethazine as required to help with getting to sleep. Retired to bed but refused to change into night clothes.
13 May	<p>Ward round with MDT. Confirmed social worker to look for alternative placement.</p> <p>Daily SOAP. Again F not fully interacting with others in group activities. Confusion noted.</p>
13 and 14 May Night	Settled evening though asking about his wife. Amenable to reassurance from staff. Retired and slept well, though refused to change in to night attire, stating he would catch pneumonia. Remained

	on general observations.
14 May	Reviewed by consultant psychiatrist. Noted to have been on EVO due to two incidents of physical aggression. His aggression reported to only be towards men, remained unpredictable. Eating and general sleeping well. Mobility good, and physical health good, but with some syncopal attacks. Noted to have ongoing risk of aggression to male patients, and risk of deterioration in mental health. Needing to be cared for in a challenging behaviour unit.
Afternoon	Section 117 meeting. Present: Consultant psychiatrist, staff nurse, liaison nurse, social worker 1 and 2, wife and niece. Unpredictable aggression and behaviour noted. Wife accepted he could not be cared for in normal EMI setting. She wanted to do what was best for him. The request relayed by the IMHA was discussed and noted (for F and wife to be together). Decided that appropriate places needed to be found by social worker and reported back to family and consultant psychiatrist. Daily SOAP. No new issues identified.
14 and 15 May Night	F putting himself on the floor, stating he was tired. Escorted to bed. Refused to change into night clothes. Slept until 2.40am. Became anxious, thinking he had left a spillage on the toilet floor, but hadn't when staff checked. Reassured and settled after a drink and biscuit.
15 May	Ward round with MDT. Noted to have refused medication previous night, and putting himself on the floor. F complaining of tooth pain. Examined by registrar but no abnormalities detected. He was already prescribed paracetamol 1000mg four times a day, but none given due to being able to eat a biscuit without pain, despite categorising his pain as 9 out of 10. Daily SOAP, no issues identified. General observations continued.
15 and 16 May Night	Initially confused but pleasant. Accepted night medication, retired to bed and agreed to put night attire on. Slept until 1.00am, then attended nurses station, very aggressive threatening with a walking stick. Refused to believe staff explanation as to why he was in hospital. Raised his stick at staff, who used four arm restraint to remove stick to protect staff. Attempted to head butt staff, and sweep their legs with his feet. Eventually agreed to stop, staff allowed him to walk away. He wandered for 30 minutes, then went to his room and slept. Up again at 5.00am, but very pleasant. Datix completed.
16 May	Section 3 rights read to him, with very little understanding. Phone call to ward from sister, who pressed for more personal information than the staff felt able to give her due to confidentiality. Daily SOAP. Episodes of aggression noted.
16 and 17 May Night	Disoriented at start of night shift. Accepted cup of tea and medication, retired at 10.00pm.

17 May	Daily SOAP. Noted to have lost 1.5kg, though good diet. No other issues noted.
17 and 18 May Night	Very quiet initially. Accepted medication. Verbal altercation occurred with fellow patient C, staff unclear how this started. Staff intervention required to de-escalate. F remained angry for a while, repeatedly stating he did not start it. Offered and accepted 0.5mg Lorazepam to good effect, and then settled for the rest of the night.
18 May	Ward round with MDT. Noted to be subdued, but pleasant and wanting to see his wife. Awaiting placement in suitable facility for his challenging behaviour. Daily SOAP. Nil of note, other than wanting to leave the ward to be with his wife, but accepting staff explanations.
18 and 19 May Night	Settled night, accepting hot drink and medication. No concerns on hourly wellbeing checks. Remains on general observations
19 May Day	Ward round with MDT. MDT noted lower in mood, but not as argumentative as previously. Diet was not as good and he had lost weight. Remained waiting for placement. For urine test. Participated in physiotherapy group. Contact from ward to social worker to ask for update on finding suitable placement. Message left as social worker away. Daily SOAP reported nil of note. EWS score = 0. Noted to have stumbled a few time, but F said he was tired. F stating he wants to go home. Still waiting for challenging behaviour placement.
3.08pm	Reviewed by consultant psychiatrist. Noted to be eating less, and slower psychomotor activity, thought to be possibly due to Carbamazepine. No evidence of previous skin rash. Worried that he didn't have any money when asked about his mood. Denied any suicidal ideas, or memory problem. Plan to remain on current medication, arrange for MSU and Liver Function Test (LFT). Risk of unprovoked and unpredictable violence remained.
3.30pm	F was sat quietly in a chair outside the office. Maureen told him to get out, as it was her chair. Staff immediately intervened and attempted to diffuse the situation, encouraging Maureen to walk away. As they were doing so, Maureen swiped at F's face with the corner of her cardigan. F jumped up and pushed Maureen in the back. This caused her to fall to the floor. F was taken away from the scene for a walk in the garden. He was initially quite angry and distressed, saying "I am the black sheep, and if anyone hits me, I hit them back harder, and no one can hit harder than me". F soon settled, then had a sleep. On waking he made no further reference to the incident. His family were informed of the incident and he was placed on 1:1 observations.

20 May	Safeguarding were informed of the previous day's incident.
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Appendix D - Chronology of Maureen's care from admission to 25 May 2015

Date	Detail
	<p>Maureen was a 69 year old lady who first had contact with MHSOP in August 2014 after being referred by her GP for assessment of her memory. She also had a history of Chronic Obstructive Pulmonary Disease (COPD) and asthma.</p> <p>She was first seen by a CPN on 21 August 2014 in the Blackhall clinic, with a recent history of forgetfulness, confusion, irritability and low mood over the last six months. She had scored 16 on the Six Item Cognitive Impairment Test (6CIT).⁶⁹ This indicated significant cognitive impairment. She was also tested using the Addenbrookes Cognitive Assessment III, (ACE III) scoring 65/ 100/ Her lowest scores were for memory and fluency. A CT scan was requested and she was to be followed up in an appointment with a consultant psychiatrist on 4 November 2014 for a diagnostic meeting.</p> <p>She was initially cared for at home by her husband, with support from Durham County Carers group. However, by 20 October, he admitted having difficulties coping to the consultant psychiatrist's secretary, and that he was having to go for a drive to calm down. He was offered respite care for Maureen on 31 October, but declined.</p> <p>At the end of November Maureen had a short period of care (four days) in University Hospital North Tees, after being admitted for a chest infection which exacerbated her dementia. She was seen shortly after this by the consultant psychiatrist, who gave a likely diagnosis of Alzheimer's Dementia and prescribed Pregabalin for her anxiety and for Donepezil to commence after the antibiotic treatment for her chest infection had completed.</p> <p>Initially this had a positive effect, and Maureen was much more settled at home, and her husband was able to care for her.</p> <p>However by the end of December and into early January there were further episodes of her husband calling the service saying he could no longer cope, due to lack of sleep. Other support provided also include attending a day service for respite, and contact with a social worker from the Coal Industry Social Welfare Organisation (CISWO).</p> <p>Maureen was reported to believe she had two husbands, one who looked after her and one who went to work. She was found to be ironing two sets of clothes for the two husbands. Her husband also</p>

⁶⁹ The 6CIT is a well validated tool that is used to test orientation in time and place, and short term memory. It is an alternative to the MMHSE. Questions are scored 0 for correct answers. Overall scores above 8 / 28 indicate cognitive impairment.

reported she had started seeing a girl in the house, but Maureen stated this wasn't a problem as she thought the girl lived with her.

Because her husband could sometimes misconstrue plans agreed with him further visits from the CPN were to be accompanied by one other person. Maureen's medication was reviewed and her Donepezil was increased to 10mg once a day.

There were further problems with contacting her husband, as his mobile phone blocked numbers it didn't recognise, and attempts to contact him from the community team often went unnoticed.

Her husband reported in February that she seemed to be hallucinating more than normal, and there were occasions when she did not recognise her husband. On one occasions she thought he was an intruder and was going to call the police.

Maureen had been attending Minerva House, a dementia day service in East Durham. However, she stated that she no longer wanted to attend, as it was full of old people, and she preferred to be in her own home. Her husband had been on sick leave from work, but was planning to return in two weeks, time and it was arranged for Maureen's daughter to sit with her for two days a week whilst he was at work. The CISWO had arranged for the enhanced rate of attendance allowance to be paid, and was sorting other benefits for the family as well.

There were periods in February of apparently settled behaviour, then further telephone calls from her husband saying he could no longer cope, He was also often critical of the services, and concerned that the people he wanted to speak to weren't available when he wanted.

Following a joint visit from her CPN and the Team Manager, a plan was agreed with her husband for Maureen to attend the Hawthorns, a neuro - rehabilitation service in Peterlee, after discussion with the consultant psychiatrist. The Donepezil was topped and the GP was informed of the plan.

Maureen's husband was increasingly less able to cope. The welfare officer from the CISWO telephoned the community mental health team with her concerns about Maureen's husband, who she stated appeared to be suffering with increased stress. Apparently Maureen was awake all night and responding to hallucinations. Maureen's husband alleged that he had slapped his wife in frustration, and out of exhaustion due to lack of sleep. She had another chest infection which had exacerbated her COPD and she was on antibiotics and steroids. Although there were no marks of injury, and no evidence that this had happened, a safeguarding alert was raised.

Following further carer crises, it became necessary to admit Maureen

	<p>to a care home in Peterlee for emergency respite care on 26 March. An emergency Deprivation of Liberty Safeguards detention was applied for and accepted.</p> <p>However, over the following few weeks, Maureen's condition deteriorated further whilst in the care home. There were signs that her chest infection had got worse, but that was not seen as a reason to explain her mental deterioration. On the 17 April, she was reported to have been attempting to hit other residents, walking round communal areas in her underwear, disinhibited and climbing over furniture. She was described as 'manic' and care staff were struggling to cope. She was seen by her consultant psychiatrist, and in order to prevent further decline in her condition, and for the safety of other residents, a recommendation for detention under Section 2 of the Mental Health Act was made.</p>
17 April 2015	<p>Maureen was admitted to Picktree Ward, Lanchester Road Hospital, Durham on 17 April under Section 2 of the MHA. She was brought in accompanied by her daughter and the AMHP (social worker). Though initially settled, she became unsettled after her daughter had left, with some confusion and a little anger. Staff attempted to provide her with her rights under the MHA but she would not engage.</p> <p>The Glasgow Coma Scale (GCS) was 15 on admission, and the Early Warning Score (EWS) was 6. The on call doctor was informed, who requested repeat EWS scoring. Maureen received an ECG and she was physically examined by the on call doctor, who was content that she stay on the ward. She was commenced on antibiotics. Maureen had her EWS taken a further three times, scoring 4, and then 3 on the final two occasions, when she was in bed.</p> <p>The Falls assessment indicated a score of 4 ticks on admission (4 or more medication, restless at night, wandering and agitation).</p> <p>As Maureen was reported to have lost weight recently she was commenced on a diet and fluid chart and fluids were 'to be pushed. Her weight was 39.2kg and height at 149.5cm.</p> <p>There is a record of the FRAX[®] tool⁷⁰ being completed which gave her a score of a 12% probability of major osteoporosis and 4.6% probability of a hip fracture over the next ten years.</p>
18 April 2015	<p>Telephone contact from husband and Peterlee care home. Husband intended to visit later that day.</p> <p>The daily SOAP indicated Maureen needed help with dressing as she couldn't coordinate clothing. Her diet was fair, but needed a lot of</p>

⁷⁰ The FRAX[®] tool has been developed to evaluate fracture risk of patients at the metabolic diseases unit, University of Sheffield. It is based on individual patient models that integrate the risks associated with clinical risk factors as well as bone mineral density (BMD) at the femoral neck.

	assistance. She was referred to the dietician and the Malnutrition Universal Screening Tool (MUST) was planned for completion.
18 April	After discussion with daughter, agreed that Maureen would not benefit from having a key to her room, as there was concern that she would lose the key.
18 and 19 April Night	One episode of disinhibition when Maureen took her trousers down/ She was taken to the toilet. Night medication accepted and slept until 5.00am. EWS score of 5, but seen as within normal range as initial baseline was 6 on admission.
19 April 2015	Fluctuating mood, hostile at time towards staff in the morning, and grateful/ happy in the afternoon. She refused her inhalers in the morning, and became breathless shouting at staff. She was verbally aggressive at times, encouraging other patients to refuse their medication. She accused a male patient of slapping her, but there was no evidence that this happened, as staff in the vicinity did not hear anything, other than Maureen wagging her finger at the other patient. Datix form completed. Refused to have EWS completed. Sexually disinhibited in the evening. Accepted 0.5mg lorazepam as required and settled. Later accepted EWS scoring = 3.
19 and 20 April Night	Unsettled, pacing around the ward and asking to go and see her dad in the evening. Refused her supper. Accepted night medication and given as required 0.5mg lorazepam. She was then reported to have had a good night's sleep.
20 April 2015	Report out with MDT. Noted recent history of aggression, and weight loss with diagnosis of dementia. She was referred to the dietician, and staff were to check if she had been referred to safeguarding. Physiotherapy assessment identified full mobility, and no further physiotherapy intervention required. She was taken off the Falls CLIP. Maureen noted to be confused by the support worker, with some hoarding behaviour. Medicines reconciliation (completed by pharmacist): Carbocisteine capsules 705mg twice a day Pregabalin capsules 50mg twice a day Salbutamol inhaler two puffs four times a day Tiotropium inhaler 18mcgs daily Uniphyllin Continuos tablets 200mg twice a day Seretide 250mcg inhaler two puffs twice a day Mirtazepine tablets 15mg at night Amoxicillin capsules 500mg three times a day Daily SOAP noted Maureen's changeable mood, her confusion and disorientation and hoarding behaviour. She refused to have her blood taken for testing, and also refused to have EWS scored. Staff were to attempt these when daughter visited.
20 and 21	Found to be hostile, threatening 'accelerated' on commencement of

April Night	night shift. She became breathless from pacing and speaking continuously. Given as required medication 0.5mg Lorazepam at 11.45pm.
21 April 2015	<p>It was noted that Maureen's husband had been contacted by her CPN and he had stated how impressed he was with the ward, although he was not happy with Peterlee Care Home and didn't want his wife to return there.</p> <p>MDT with consultant psychiatrist, registrar, staff nurse, psychologist and trainee psychologist. Noted to be very confused and disoriented Verbally abusive, misinterpreting things, sexually disinhibited, varying sleep pattern. The plan was to increase her Mirtazepine to 15mg twice daily, and arrange for a formulation and admission meeting.</p> <p>Attempted unsuccessfully to obtain blood for routine admission tests, including when with daughter.</p> <p>Daily SOAP reports predominantly settled, but taking small diet only and hiding food in her bag.</p>
21 and 22 April Night	Grossly confused on commencement of night shift, becoming anxious due to verbally abusive patient. Refused supper, but accepted Mars bar and cup of tea. Reassured and settled night afterwards.
22 April 2015	<p>Report out. Noted to have Mirtazepine increased to 15mg twice a day and EWS ranging from 3 – 4.</p> <p>Attended physio group.</p> <p>Reviewed by registrar. Chest infection noted to be improving.</p> <p>Daily SOAP records spending time with her husband, but some confusion and flight of ideas. She was mobilising independently.</p>
22 and 23 April Night	Noted to be disoriented in place and time, invading other patient's spaces, hostile to staff, wandering the ward all night, taking her clothes off. Voiced that she hadn't been offered food or a drink (even though there was a drink in front of her) and that her husband and dad were coming to see her, and she would leave with them.
23 April 2015	<p>Seen by assistant psychologist.</p> <p>Reviewed by consultant psychiatrist. Identified that she had moderate to severe Alzheimer's dementia, and her recent psychological disturbances were precipitated by her chest infection and prolonged use of prednisolone (stopped on 22 April). Reported to be eating and sleeping.</p> <p>Daily SOAP reports fluctuating behaviour, from friendly to aggressive and angry.</p>
23 and 24 April Night	Unsettled and elated in mood, difficulty concentrating jumping from one topic of conversation to another. Eventually retired and slept from midnight.
24 April 2015	Report out, Poor diet and fluid intake noted.

	<p>MSU results showed no sign of urine infection.</p> <p>Daily SOAP reported a settled day, interacting with staff. Recognised her daughter, though disoriented in place and time, EWS score = 4. Small diet and snacks taken.</p>
24 and 25 April Night	<p>Agitated on commencement of night shift, and becoming short of breath. As required Lorazepam 0.5mg given. Taken a good diet at supper, and retired at 9.45pm. Settled to sleep from midnight.</p>
25 April 2015	<p>Tearful in the morning, missing her husband.</p> <p>During the afternoon Maureen was reported to be upset and agitated, invading other people's personal space. Staff heard Maureen scream, when they attended they found Maureen in the main corridor with fellow male patient F, who was holding up a walking stick whilst Maureen was shouting at him. Maureen stated that F had hit her on the arm with his stick. When staff spoke to F he denied that he had hit her with his stick.</p> <p>Maureen was checked by staff and no injuries were identified, evidence within the notes that Maureen's husband was informed of the incident and that his wife was unhurt when he visited in the afternoon. Datix completed.</p> <p>Maureen's husband given back cigarettes, lighter, mobile phone and money he had previously left with her, as she was leaving them around the ward.</p> <p>Maureen was later found smoking in her room.</p>
25 and 26 April Night	<p>Settled evening and night. Retired at 10.30. Up once, disoriented, but settled after reassurance given.</p>
26 April 2015	<p>Maureen was reported to be bright, pleasant and engaging well with both staff and fellow patients. She required minimal prompts and assistance with self-care. Her speech was reported to be rapid and accelerated at times but she was able to make her needs known to staff. Her behaviour was reported to be settled, wandering the ward at times with no agitation or anxiety observed.</p> <p>Maureen was mobilising independently without issue. Physical observations – EWS=4, Weight - 41.3kg, MUST 1 Good diet/fluids accepted</p>
26 and 27 April Night	<p>Refused supper, but Maureen accepted medication and cup of tea. Given as required Zopiclone for sleep. Settled night though up once disoriented.</p>
27 April 2015	<p>Maureen was described as pleasant and engaging well with staff and patients although confused at times stating she had been robbed. She was also reported to appear to be 'manic and accelerated'.</p> <p>She was mobilising independently and her physical observations were</p>

	<p>as follows EWS = 2, no physical health abnormalities noted, accepting little diet and fluids.</p> <p>Given as required Lorazepam 0.5mg.</p>
27 and 28 April Night	Pleasant and amenable, allowed night staff to complete EWS (Score = 1). No breathlessness noted, and inhalers given.
28 April 2015	<p>Maureen was reported to be in a good mood, spent time chatting with staff and fellow patients. She was visited by her husband during the afternoon where they both spent time making cards.</p> <p>MDT with consultant psychiatrist, registrar, psychologist, staff nurse and Picktree manager. Noting prompted needed for dressing and eating, but some weight gain. Much improved with regards to aggression and attempts to abscond. Comment that husband appeared unrealistic with regard to his wife's abilities and possible future care. Formulation meeting for 8 May. Mirtazepine increased to 30mg at night and Memantine to 10mg.</p> <p>Daily SOAP completed. Cognition - Appeared to lack insight into her illness. Physical observations - Scored 2 on EWS, no concerns regarding physical health accepting little diets and fluids.</p> <p>Family contacted regarding the medication changes, the effectiveness and side effects of the medication. Maureen's husband stated he felt he had seen some improvement in his wife's presentation stating he wanted his wife to go back home with him on discharge.</p>
28 and 29 April Night	EWS score = 1. Bright and pleasant, conversing with staff.
29 April 2015	<p>Report out and MDT: Noted as 'not settled', accepting her medication and taking small diet.</p> <p>Assessed by OT, Pool Activity level completed, scored overall at planned level. But five activities scored as exploratory. This identified that usual and familiar objects should be kept in the same place, but new or unfamiliar activities needed to be in line of sight, and that she may not be able to understand complex sentences. Became agitated towards the end of the assessment, wanting the OT to help her look for her children, and trying to take the OT paperwork, believing it to be hers.</p> <p>Safeguarding referral following the incident on 25 April 2015 recorded in notes.</p> <p>Daily SOAP. Stated that she felt frightened of the woman in the room opposite her. Spent some time looking for her husband and children. EWS score = 2.</p>
29 and 30 April Night	Anxious on commencement of night shift, settled after telephone call with daughter. Cup of tea and sandwiches at super, settled and slept

	night.
30 April 2015	<p>Admission meeting with consultant psychiatrist, team manager, Maureen's husband, Staff nurse (Picktree ward) Manager from Peterlee Care Home, and staff from Minerva House (volunteer day service). Reasons leading to admission discussed. Maureen's husband again stated he had said he had hit her, but this was due to stress and he needed help, and that he hadn't hit Maureen at all. He was offered the opportunity to join the carer's education group. The outcome of the meeting was a plan to offer Maureen's husband support and continue with assessment.</p> <p>Maureen presented as tearful at times requesting to go home re-assurance given by staff Maureen responding well to the intervention. Mobilising safely, EWS completed no score available within Maureen's electronic record. There was no concern noted regarding Maureen's physical health she ate very little breakfast, due to low mood, but did have a good diet intake for the rest of the day.</p> <p>EWS scoring = 7, ward doctor informed. Plan for repeat EWS and ECG if pulse over 130. EWS score = 4.</p>
30 April and 1 May Night	<p>Angry at start of night shift. Maureen had been given as required Lorazepam 0.5mg prior to night shift. Retired to bed at 8.30pm. EWS score = 6.</p> <p>Awake at 11.30pm, becoming angry and disoriented. Maureen thought she was going to work. Refused EWS. Eventually settled by 1.00am.</p>
01 May 2015	<p>Maureen was reported to be bright and reactive in mood, elated in presentation at times, experiencing anxious periods wanting to see her husband becoming breathless on anxiety.</p> <p>Maureen's EWS scores were completed throughout the day and continually scoring 5, though it was reported that Maureen's respirations were raised and her SATS were low. No record of scoring done on the EWS score charts.</p> <p>Formulation meeting on Bowes Lyon unit.</p>
1 and 2 May 2015 Night	<p>More settled night, asking staff when she could have her inhalers. Accepted medication at 9.45pm.</p>
02 May 2015	<p>Maureen was reported to be pleasant in mood and was very helpful around the ward enjoyed helping staff to wash up in the kitchen. Chose not have breakfast but had a drink and two oranges. Speech confused, believing that she had been to the shopping centre earlier on in the day. EWS score = 2, plan for this to be repeated in 4hours.</p> <p>Rights under Section 2 MHA read to Maureen. She is reported to have shown no understanding or insight that she was in hospital. Said she was happy to stay in this house.</p>
2 and 3 May 2016 Night	<p>Maureen settled and pleasant mood. As required Zopiclone give. Slept through the night.</p>
03 May 2015	<p>Daily SOAP.</p> <p>Independent with care, but reported to be dressing and undressing few</p>

	times. Disoriented for time. EWS score = 3 at 3.21pm, for repeat at 5.00pm.
3 and 4 May Night	Maureen became restless, anxious and wanting to go back to her husband at around 8.00pm. She became breathless and did not respond to staff attempts to reassure her. She became angry and irritable in mood towards other patients and female staff, shouting expletives at people for no apparent reason. Maureen was offered and accepted as required Lorazepam 0.5 mg and a Salbutamol inhaler. She is reported to have continued to wander, eventually settling and sitting with staff. She accepted as required Zopiclone 3.75mg to help her sleep at 11.00pm, and retired at 11.30pm, then slept well.
4 May 2015	Maureen was described as restless, irritable and angry on occasions. Small diet and fluids taken with encouragement from staff. She was visited by her husband and they spent time in the ward garden. EWS score at 1.30pm was 7, retaken at 5.30pm, score = 5
4 and 5 May Night	At the commencement of the night shift Maureen was noted to be elated at times raising her voice shouting that she was going home blowing kisses towards another patient. She is reported to have eaten a small supper, complaining about her feet being swollen before retiring to bed. It is reported that she later came out of her bedroom shouting due to another patient entering her room. She was reassured that this would not happen again. She retired to bed and slept well.
5 May 2015	MDT meeting. Maureen was noted to be much improved still has some anxious episodes, with periods of acceleration where she would pace quickly around the ward, and at times being argumentative but overall no management problem. Her husband was happy to have her home, with a care package. He was also offered carers education. She was reviewed by the registrar for oedematous feet. Bilateral pitting oedema up to the second third of her legs confirmed. No signs of inflammation and no pain to compression. On chest examination, clear chest, no wheezes, crackles or rhonchi. Due to increased risk of low BP, prescribed minimum dose of Furosemide 20mg instead of changing dose of 40mgs. Plan: Furosemide 20mgs for 7 days then review. EWS score = 3. Daily SOAP did not identify and new physical problems. Meeting to be convened to discuss aftercare planning under Section 117 MHA.
5 and 6 May Night	A little disgruntled at commencement of night shift, but retired independently and settled night.
6 May 2015	Report out. Maureen was reported to have been angry in mood when

	<p>she woke, very fixed on her feet and inhalers, she could not recall that she had been given her Furosemide and was shouting at staff.</p> <p>Daily SOAP completed which identified that Maureen's interactions had improved during the day. Her self-care was independent. EWS = 3 at 12.25pm, scored again at 5.30pm = 3.</p> <p>Recorded that Continuing Health Care (CHC) checklist completed and faxed to CCG.</p>
6 and 7 May Night	EWS at 10.55pm = 5. Otherwise settled night.
7 May 2015	<p>Reviewed by consultant psychiatrist. Her speech was coherent but irrelevant most of the time. Though improvement noted, the consultant psychiatrist felt Maureen remained at risk due to her deteriorating mental health which potentially negatively affected her physical health and safety. The consultant psychiatrist therefore concluded that a MHA assessment was required to regrade Maureen's section from a Section 2 MHA to a Section 3 MHA as Section 2 due to expire in one week.</p> <p>Pre-discharge meeting / Section 117 MHA meeting with consultant psychiatrist and MDT. Discussed that Maureen was calmer and more pleasant. She presented as disorientated to time and place and was unable to tell who were her daughter and husband.</p> <p>Plan: Occupational Therapist (OT) to carry out ward and home based assessment. Maureen was granted home leave, and for graded home leave prior to discharge. Assessment for section 3 MHA (booked for next week – Tuesday) Formulation meeting at 10.00a.m, 08 May 2015 Memantine increased to 15mgs</p> <p>Daily SOAP completed no new risks identified. EWS score = 3 at 10.40am. Scored again at 5.00pm = 4.</p>
7 and 8 May Night	Prior to retiring to bed Maureen was reported to be occasionally 'a little wandersome', confused and disorientated and at times verbally repetitive with a slightly raised voice. She is reported to have accepted medication before retiring to bed and slept well. EWS could not be repeated as she had gone to bed.
8 May 2015	<p>Maureen was described as being generally bright, friendly and jovial.</p> <p>Her husband requested that a doctor review his wife due to her level of breathlessness and also the pains and cramps in her legs and feet. The staff spoke with the doctor on the ward who stated they would contact Maureen's GP. In the interim the doctor recommended for the cramps 'that Maureen be given bananas and if they were not effective then medication would be considered'. Maureen was reported to be a</p>

	<p>little tearful when her husband left the ward following his visit.</p> <p>Daily SOAP completed, identified that Maureen's feet were oedematous, she was compliant with her Furosemide and when sitting her feet had been raised. Maureen stated that she was grateful for all the care attention and friendship she had experienced, but she wanted to go home to be with her husband.</p> <p>Decision Support Tool (DST) meeting cancelled due to likelihood of being put on Section 3 MHA when Section 2 MHA expires.</p>
8 and 9 May Night	A little anxious at start of night shift but settled and slept well. As required Zopiclone given to good effect.
9 May 2015	<p>Daily SOAP completed. Maureen was identified as remaining quite confused and disorientated, pleasant in mood with odd bouts of anxiety. Maureen's EWS = 5 at 11.30am, and a request was made for the EWS to be retaken later in the day. No new risks identified and Maureen remained on general observations. Maureen refused the EWS at 3.30pm. EWS re-taken at 5.20pm, scoring 6.</p> <p>Rights under Section 2 MHA explained to Maureen, using 'easy read' version. Demonstrated no insight or understanding, For family and IMHA involvement in decision making.</p>
9 and 10 May Night	Settled night, supper taken and slept well. Small rash on legs noted. E45 cream applied.
10 May 2015	Maureen was reported to be mainly bright in mood, but presenting tearful at times, daily SOAP completed with no note of concern.
10 and 11 May Night	Prior to retiring to bed Maureen became anxious about a "flight that she thought she might miss". At that point it was observed that Maureen became breathless and inhalers were administered. She had an unsettled night coming out of her room on numerous occasions to enquire about the flight time.
11 May 2015	<p>Report out: discussed waiting for OT home assessment.</p> <p>Maureen reported to have participated in a game of quoits and interacted well with others during the game. Her mood continued to fluctuate and at times Maureen had become a little tearful but accepting of support from staff.</p> <p>Daily SOAP was completed with no note of concerns. Formulation meeting using Columbo model recorded, with recommendation covering Maureen's activities, interests, daily living skills and risks. In attendance husband, team manager, staff nurse, clinical psychologist, and assistant psychologist.</p> <p>Maureen initially declined to have her daily EWS taken but then agreed EWS scoring 4.</p>
11 and 12 May Night	Settled and quiet. Retired to bed independently.

12 May 2015	<p>MDT meeting with consultant psychiatrist, registrar staff nurse, CPN, clinical psychologist and trainee psychologist. Note for Section 3 MHA assessment today and Section 117 MHA meeting to be arranged.</p> <p>Section 2 MHA converted to Section 3 MHA after assessment by AMHSP and further recommendation by another consultant psychiatrist. Agreed that Maureen needed to remain in hospital until care package could be arranged, after OT home assessments.</p>
12 and 13 May Night	<p>It was reported that in the evening Maureen was sitting outside the office where she appeared anxious stating that she was not able to breathe. EWS scores presented as erratic SATS scoring at 93 with raised respirations. Maureen was advised to rest but instead insisted on having a cigarette despite advice from nursing staff not to do so. She was advised to use salbutamol inhaler and given further prescribed inhaler. Maureen retired to bed where her breathing became more relaxed, she settled and slept well.</p>
13 May 2015	<p>Report out/ MDT meeting. Detention under Section 3 MHA noted.</p> <p>Maureen took part in the seated exercise programme on the ward, no new problems noted or reported. Maureen interacted well with staff and other patients.</p> <p>Daily SOAP completed. Maureen was visited by her husband where they spent some time together in the garden.</p> <p>Husband visited at home by community team manager and community support worker.</p>
13 and 14 May Night	<p>A little anxious about bedroom door locked, and not able to get her handbag. Once door opened, she settled, retired to bed independently.</p>
14 May 2015	<p>Report out/ MDT meeting. Noted Section 117 meeting to be arranged.</p> <p>Seen by the OT for introduction in preparation for the home assessment which was planned for the 19 May 2015. Maureen was reluctant to engage with the OT stating "can't be doing with answering these questions everything is sorted out and I have my things here". Maureen declined to engage and left the room.</p> <p>Blood test results identified TSH⁷¹ 0.22mU/L (normal range = 0.35-5.5mU/L) a free T3 was requested.</p> <p>Report out by consultant psychiatrist. Noted that chest infection now resolved, and previous history of recurrent chest and urinary tract infections, She was assessed as appropriate in speech and behaviour, and euthymic. No insight in to her mental health. Ward OT assessment completed. Plan for home assessment and Section 117 MHA meeting. Memantine to be increased to 20mg from next week.</p>

⁷¹ TSH is Thyroid Stimulating Hormone. Low or high levels can cause abnormalities of metabolism.

14 and 15 May Night	Asleep at commencement of night shift. Night medication accepted, settled night.
15 May 2015	<p>Full assessment completed by the physiotherapist for complaint of pain in Maureen's right shoulder. Assessment identified that Maureen overuses her shoulder muscles due to COPD. Maureen was not experiencing any pain at the time of assessment and had full range of movement. For further monitoring.</p> <p>Maureen was visited by her husband, who was looking forward to having her home, and the home assessment next week. Daily SOAP completed with nil of significance noted. Maureen remained settled on the ward excepting medication, diet and fluids.</p>
15 and 16 May Night	In her room at start of shift. Refused supper, but accepted cup of tea and night medication, Maureen was complaining of feeling unwell, showing signs of a cold or hay fever. Slept well.
16 May 2015	<p>Daily SOAP completed Maureen remained confused and disorientated with anxious periods, awaiting OT home assessment that was planned to take place on 19 May 2015. Throughout the day there was no record of any aggression or agitation. Maureen's rights under section 3 MHA were read to her, it is recorded that Maureen had no understanding of her rights under the act Form 132A was completed.</p> <p>EWS = 2. No further complaints of pain.</p>
16 and 17 May Night	Initially very disgruntled, and getting more agitated with staff attempting to identify the problem. Coming out of her room in state of undress, shouting loudly at staff and patients. Reported to be obviously very angry. Eventually retired to bed, accepted night medication, and once settled appears to have slept well.
17 May 2015	Daily SOAP completed, remained confused and disorientated becoming agitated and argumentative after lunch. This was noted as becoming a pattern in her behaviour. Maureen's mood fluctuated throughout the day she became anxious at times asking when her husband would visit.
17 and 18 May Night	Bright and pleasant initially, retired to bed independently after medication and cup of tea. Came out of her room a little later, anxious and breathless, as she could not see anybody about. Staff spent time with her, giving reassurance, and she settled, and slept afterward.
18 May 2015	<p>Report out/ MDT. No change noted.</p> <p>There is evidence within Maureen's notes that a mental state assessment had been undertaken.</p> <p>Maureen was upset that her daughter and her husband didn't get on, spent time talking to staff about her family. She was visited by her husband during the afternoon.</p> <p>EWS score 1, no concerns raised in relation to Maureen's physical health. She consumed a good diet and fluids and was compliant with all prescribed medications.</p>
18 and 19	Anxious at start of night shift, believed she was getting married in the

May Night	<p>morning. She became breathless with exertion and anxiety. Accepted medication including inhalers, which improved her breathing and she relaxed more. Retired to bed, though slow to settle, coming out of her room on occasions, confused and sometimes angry.</p>
19 May 2015 15.07hrs	<p>MDT meeting with consultant psychiatrist, registrar, staff nurse and CPN. Noted to be settled but confused, getting breathless when anxious, but accepting as required medication with good effect.</p> <p>Maureen was reported to be bright in mood during the morning before going home for her OT assessment.</p> <p>Entry from the Occupational Therapist (OT) following the planned home visit to carry out the home assessment.</p> <p>Maureen's husband was committed to the caring role for his wife, he demonstrated insight and good care strategies to meet his wife's needs. Maureen was reported to be initially anxious on returning home but soon settled and relaxed, engaged in all aspects of the assessment. Observation made by the OT recommended discharge home without a graded leave programme.</p> <p>Maureen's husband was keen to care for his wife without a formal care package with the exception of day care. The OT noted there was no evidence of carers stress and acknowledged Maureen's husband was keen to have his wife home and was accepting of community support.</p> <p>It was recorded that Maureen returned from her home assessment she presented as bright in mood and enjoyed telling staff about her time at home.</p>
19 May 2015	<p>At approximately 15.30hrs a member of staff on the ward observed Maureen approach a male patient (F) telling him "get out of my seat". The staff member attempted to divert Maureen away from F. As Maureen walked away from F she gestured / lashed out at F with her fleece. She had her hand wrapped in her fleece. Maureen continued to then walk away with the staff member. At that point F jumped from his seat and pushed Maureen in her back causing her to fall to the floor landing on her left side.</p> <p>On landing on the floor Maureen was upset and complaining of pain to her left leg. This was rotated to the left with some shortening of the limb. Seen by the registrar, X-ray form completed and ambulance called. Maureen was made comfortable on the floor with pillows behind her back. Paracetamol given as prescribed. The Glasgow Coma scale was completed scoring 15. EWS was partially completed. Staff made a clinical decision not to obtain a blood pressure as Maureen was wearing a large jacket and staff were reluctant to remove the jacket due to the pain they would cause Maureen. Temperature taken 37.3, pulse 117, O² Sat's 95%, Respiration 20.</p>

	<p>There are records of discussions between ward staff and the ambulance service regarding transfer timings and advice to ward staff from the ambulance service during the wait for the ambulance. Ambulance arrived and Maureen was taken to the A&E at University Hospital North Durham (UHND) at 5.30pm. She was escorted by a nursing assistant and a copy of her prescription sheet, personal information sheet and X-ray request was sent with them.</p> <p>Maureen's husband was informed of the incident and kept up to date with information. He is reported to have been understanding of the situation.</p> <p>Maureen was transferred to Ward 12 UHND that evening. Picktree ward staff remained with Maureen through the night in case she became unsettled or agitated.</p>
20 May 2015	<p>A fractured neck of femur was confirmed and Maureen underwent surgery for a hip replacement in the morning. She returned to the ward that afternoon.</p> <p>Picktree ward staff updated her husband on her progress, though there remained difficulties getting through to him from hospital phones routed via switchboards, and had to use a mobile phone.</p>
21 May – 25 May 2015	<p>Maureen's condition worsened after her surgery. She went into urinary retention, and staff (including a urologist) were unable to catheterise her. She was given a suprapubic catheter on 23 May. Her oxygen levels were low post operatively, and she was diagnosed with a chest infection and given intravenous antibiotics. However she did not respond to the antibiotics, and went into sepsis.</p> <p>Maureen died at 9.30am on 25 May 2015.</p>